West Virginia
Maryland
Virginia
Washington D.C.

2023 Virtual Council Meeting
May 1, 2023 – April 30, 2024 Performance Period

Quality Insights
Renal Network 5

May 25, 2024, Session #2

Objectives

- Introduce Network purpose, geography, and staff
- Describe current statement of work
- Celebrate Option Period 1 (OP1) outcomes
  - Recognize top performers
- Define opportunities for collaboration and expectations

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Network Purpose

- ESRD Networks are dedicated to assisting dialysis facilities and kidney transplant centers in their efforts to provide quality care for people with ESRD

- 18 ESRD Networks contracted by CMS under the ESRD Program established as part of the Social Security Administration in 1972, to help assure that people with ESRD receive proper care

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Conditions for Coverage

- CMS established regulations that in order for facilities to be certified under the Medicare program, the CfC must be followed.

  – "The dialysis facility must cooperate with the ESRD network designated for its geographic area, in fulfilling the terms of the Network's current statement of work. Each facility must participate in ESRD network activities and pursue network goals." *42 CFR 494.180(i)*

- Partner with State Survey Agency to ensure CfC are met.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-494?toc=1

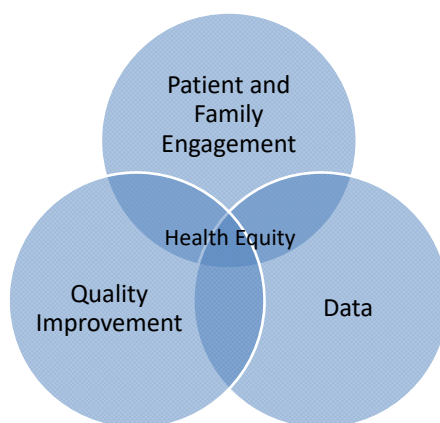Quality Insights

Overview of ESRD Network 5

- Quality Insights Renal Network 5 (QIRN5)
  - Formerly Mid-Atlantic Renal Coalition (MARC)
  - AKA "The Network" or "Network 5"
- District of Columbia, Maryland, Virginia, West Virginia
- 27,628 Dialysis Patients (16% home dialysis patients)
- 18,046 Transplant Recipients

State	Medicare Dialysis Facilities	Medicare Transplant Centers
	443	**13**
DC	23 (5%)	3 (24%)
MD	170 (39%)	2 (15%)
VA	209 (47%)	6 (46%)
WV	41 (9%)	2 (15%)

Data Source: Facility Reports_NW5_20230411 Provided by ESRD NCC

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Current Statement of Work

- Patient and Family Engagement
- Health Equity
- Quality Improvement
- Data

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Quality Improvement Specialists

Katelynn Booth, MSN, RN

Danelle Jefferson, MSN, RN

Amanda Morelli, MSN, RN

Elizabeth Nuschke, RD

Topic Lead	**Danelle Jefferson, MSN, RN**
QIA	Depression
Network Goal	• Achieve a 10% increase in the percentage of patients receiving, or having received, treatment by a mental health professional after having been screened positively for depression, as identified in the QIP attestation. • Goal to be achieved by April 30, 2024
Facility Responsibilities	• Record screening outcomes in EQRS, make sure data in EQRS is accurate. • Identify a plan for **ALL** patients who screen positive for depression

Behavioral Health – OP1

- Renalis Pineview
- Courtland Dialysis
- Capital Region Dialysis
- DaVita Whitesquare
- FMC – Elkton
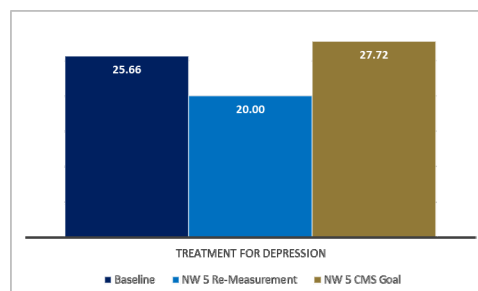
Behavioral Health – Tips

- Identify a "warm list" of local behavioral health providers
- Understand the co-occurrence of mental illness and inadequate health literacy; implement health literacy interventions to help address limited health literacy among those who screen positive for mental illness
- Prioritize referring patients without a PCP to a physician associated with a Primary Care Behavioral Health (PCBH) model
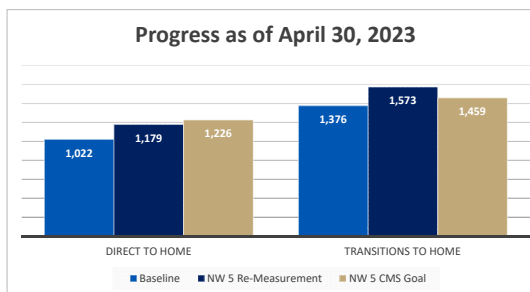
Topic Lead	**Elizabeth Nuschke, RD**
QIA	Home
Network Goals	• Achieve a 30% increase in the number of incident ESRD patients starting dialysis using a home modality. • Achieve a 12% increase in the number of prevalent ESRD patients moving to a home modality. • Achieve a 3% increase in the number of rural ESRD patients using telemedicine to access a home modality. • Goals to be achieved by April 30, 2024
Facility Responsibilities	• Identify which patients qualify for the telemedicine measure and document any telemedicine in EQRS

Home Modalities – OP1

- Direct to Home
  - DaVita Tidewater Home Dialysis
  - DaVita Hampton Roads Home Training
  - Kempsville Home Dialysis
  - Davita James River Home Dialysis
  - Kaiser – Tysons Corner
- Transitions to Home
  - DaVita Renal Care of Lanham
  - DaVita Grand Central Dialysis
  - DaVita Kidney Home Center PD
  - RAI-Medical Drive – Gloucester
  - UVA Lynchburg Dialysis

Progress as of April 30, 2023

	DIRECT TO HOME	TRANSITIONS TO HOME
Baseline	1,022	1,376
NW 5 Re-Measurement	1,179	1,573
NW 5 CMS Goal	1,226	1,459

Home Modalities - Tips

- Provide education for ALL staff, especially PCT's, on home modalities.
- Utilize patient peer mentors to talk to other patients about home modalities
- Develop life plans with patients to identify benefits of home modalities
- Discuss these goals with medical director during QAPI meetings. Establish a plan for addressing direct to home goals, if applicable.
- Consider hosting a separate meeting with the home program and medical director to review any office patients with a GFR <20 and establish a plan for modality education
- Communicate regularly with any modality educators to review office patients who may be approaching dialysis
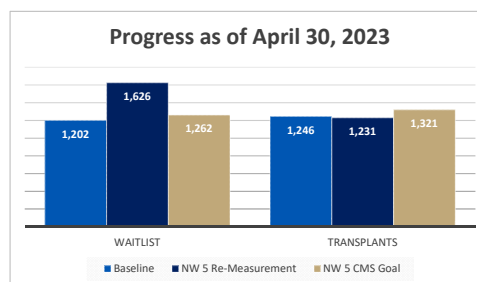
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Topic Lead	**Elizabeth Nuschke, RD**
QIA	Transplant
Network Goals	• Achieve a 9% increase in the number of patients added to a kidney transplant waiting list. • Achieve a 12% increase in the number of patients receiving a kidney transplant. • Goals to be achieved by April 30, 2024
Facility Responsibilities	• Review transplant dashboard in EQRS monthly

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Transplant – OP1

- Additions to Waitlist
  - DaVita Hioaks Dialysis
  - BMA – Crystal Spring
  - DaVita Park Hill Dialysis
  - RAI – Mechanicsville TRNPK
  - FMS - Charleston
- Transplants Received
  - DaVita Tidewater Home Dialysis
  - Renal Carepartners – Fairfax
  - DaVita Hioaks Dialysis
  - University of Virginia Hospital
  - RAI – Mechanicsville TRNPK

Progress as of April 30, 2023

	WAITLIST	TRANSPLANTS
Baseline	1,202	1,246
NW 5 Re-Measurement	1,626	1,231
NW 5 CMS Goal	1,262	1,321

■ Baseline ■ NW 5 Re-Measurement ■ NW 5 CMS Goal

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Transplant – Tips

- Provide education for all staff, especially PCT's, on transplant
- Establish regular communication with transplant centers
- Utilize patient peer mentors to talk to other patients about transplant
- Develop life plans with patients to identify benefits of transplantation
- Raise awareness of the intersection of oral health, chronic disease, and disparities to accessing transplantation
- Discuss transplant with patients face to face, in addition to any written and audio/visual education received
- Establish a tracking system to monitor patient interest and progress during workup and wait listing
- Educate patients on living donation and high KDPI kidney options
- Help patients stay "transplant ready" by discussing the mental and emotional aspects; as well as, stay on top of labs and testing

Quality Insights

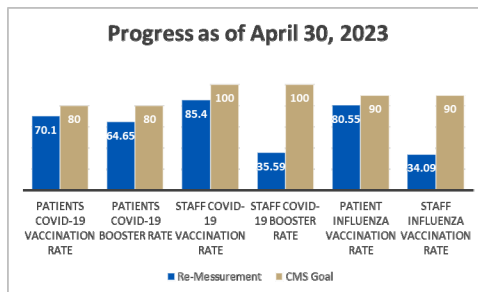| Topic Lead	Elizabeth Nuschke, RD
QIA	BMI
Network Goal	• Achieve a 4% decrease in average body weight, among prevalent ESRD patients identified as obese. • Goal to be achieved by April 30, 2024
Tips	• Be patient new project and more information will be coming soon.

Topic Lead	Amanda Morelli, MSN, RN
QIA	Vaccinations
Network Goals	• Ensure at least 80% of dialysis patients are fully vaccinated for COVID-19, including boosters, as determined by the CDC and/or CMS. • Ensure at least 95% of dialysis facility staff are fully vaccinated for COVID-19, including boosters, as determined by the CDC and/or CMS. • Ensure at least 90% of dialysis patients receive an influenza vaccination. • Ensure at least 90% of dialysis facility staff receive an influenza vaccination. • Achieve a 7% increase in the percentage of dialysis patients that are fully vaccinated for pneumococcal pneumonia. • Goals to be achieved by April 30, 2024, **data needs to be entered by April 7, 2024**
Facility Responsibilities	• Ensure staff influenza and COVID-19 vaccinations are reported in NHSN. • Ensure patient COVID-19 vaccinations are reported in NSHN.

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Vaccinations – OP1

- Patient Influenza Vaccinations
  - DaVita Dundalk Dialysis
  - DaVita Garrisonville Dialysis
  - DaVita Kidney Care of Largo
  - VCU Medical Center
  - DaVita Camelot Dialysis
- Patient & Staff COVID-19 Vaccinations
  - Kaiser Health Plan of the Mid-Atlantic States
  - Advance Dialysis Center – Rockville
  - Advance Dialysis Center – Crofton
  - Raceway Dialysis Center
  - Somatus Dialysis of Falls Church

Progress as of April 30, 2023

	Re-Measurement	CMS Goal
PATIENTS COVID-19 VACCINATION RATE	70.1	80
PATIENTS COVID-19 BOOSTER RATE	64.65	80
STAFF COVID-19 VACCINATION RATE	85.4	100
STAFF COVID-19 BOOSTER RATE	35.59	100
PATIENT INFLUENZA VACCINATION RATE	80.55	90
STAFF INFLUENZA VACCINATION RATE	34.09	90

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Vaccination - Tips

- Create a pro-vaccination environment
- Involve the entire team, including nephrologists and nurse practitioners in the education process.
- Continuously follow-up with staff and patients regarding COVID vaccinations and boosters received outside of the facility in order to have accurate tracking of vaccinations.

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Topic Lead	Danelle Jefferson, MSN, RN
QIA	Hospitalizations
Network Goals	• Achieve a 4% decrease in hospital admissions. • Achieve a 4% decrease in hospital 30-day unplanned readmissions. • Achieve a 4% decrease in outpatient emergency department visits. • Goals to be achieved by April 30, 2024
Facility Responsibilities	• Ensure discharge paperwork is received for each patient discharged from hospital within 3 days of returning to the facility • Complete Root Causes Analyses on 30-day readmissions • Have open communication between care settings (dialysis facility, hospital, nursing homes, etc.)

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Hospitalizations – OP1

- **0 Hospital Admissions**
  - Legacy Dialysis of Virginia
  - DaVita Hopewell Dialysis
  - DaVita Queen Anne Home
  - DaVita Southern Tide
  - FMC - Weston
- **0 ED Visits**
  - FMC Franklin Square Home
  - DaVita Greenbelt Home Training
  - FMC Upshur County
  - DaVita Golden Mile
  - DaVita Lynchburg Home

Metric	Upper Limit	Re-Measurement	Goal Achieved
Admissions	2.95	3.03	No
ED Visits	1.8	1.79	Yes
30 Day Readmissions	9.4	10.1	No

- **0 30 Day Readmissions**
  - DaVita Harrisonburg
  - UVA Lynchburg
  - FMC – Hagerstown
  - FMC – Denbigh
  - DaVita Washington County

Data Source: Medicare Claims as of March 31, 2023

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Hospitalizations - Tips

- Build a "warm list" of primary care providers.
- Access assessment completed prior to each dialysis session; complete access surveillance at least monthly to allow for early intervention to access related issues.
- Monthly EDW assessments and more frequently if patient is leaving more than 1kg above or below EDW.
- Monthly medication reconciliations and more frequently if there are medication changes
- Routine blood pressure assessments (identify patients with uncontrolled hypertension and discuss as an IDT)
- Utilize a tracking tool to monitor hospital visits each month, including admission diagnoses, frequent utilizers, and ensuring discharge paperwork is received
- Collaborate with local pharmacies to ensure patients are picking up/refilling their medications as appropriate
- Monitor missed treatments and offer incentives for patients to attend all treatments
- Provide routine education to patients about the risks of missed treatments and how they result in decreased quality of life and increased mortality
- Train staff members on how to handle missed treatment call from patients (ex: prompt rescheduling, identifying root causes)
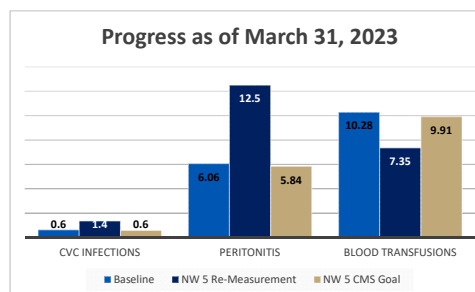
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Topic Lead	Katelynn Booth, MSN, RN
QIA	Nursing Homes
Network Goals	• Achieve an 6% decrease in the hemodialysis catheter infection rate, among dialysis patients receiving home dialysis within a nursing home. • Achieve a 3% decrease in the peritonitis infection rate, among dialysis patients receiving home dialysis within nursing homes. • Achieve a 3% decrease in the rate of blood transfusions, among patients receiving dialysis in nursing homes. • Goals to be achieved by April 30, 2024 ***For Home Dialysis Providers in Network 5 That Provide Dialysis to Patients Who Reside in Nursing Homes***
Facility Responsibilities	• Report new nursing home contracts within 30 days using online link found on Nursing Home page under Ongoing Projects tab: https://www.surveymonkey.com/r/NHPartnershipReporting • Utilize a communication/handoff tool for each transition of care

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Nursing Home – OP1

- 0 CVC Infections
  - DaVita Renal Care of Lanham
  - FMC – Montgomery
  - Dialyze Direct – Maryland
  - Dialyze Direct - Virginia
- 0 Peritonitis
  - DaVita Good Samaritan
  - DaVita Kidney Center
  - FMC – Montgomery
  - Western Maryland Regional
- 0 Blood Transfusions
  - FMC – Ripley
  - Western Maryland Regional
  - Liberty Dialysis – South Hill
  - DaVita Good Samaritan
  - DaVita Landsdowne

Progress as of March 31, 2023

	CVC INFECTIONS	PERITONITIS	BLOOD TRANSFUSIONS
Baseline	0.6	6.06	10.28
NW 5 Re-Measurement	1.4	12.5	7.35
NW 5 CMS Goal	0.6	5.84	9.91

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Nursing Home - Tips

- Communicate with the nursing home staff on a routine basis to discuss mutual patients, including upcoming appointments, risks for hospitalizations, and new problems
- Develop a process with nursing home partners when patients are hospitalized so you can stay informed about their care
- Ensure nursing home staff are educated on a routine basis about catheter care, signs/symptoms of infection (CVC/PD), and other unique care aspects of the dialysis patient
- Take advantage of the CDC's audit tools (catheter care, handwashing, exit site care, etc.)
- Collaborate with the nursing home medical team about the importance of anemia management in dialysis patients and develop procedures around appropriate use of blood transfusions
- Encourage permanent access placement when appropriate
- Involve nursing home partners in monthly QAPI meetings

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Patient Engagement Specialists

René**e Bova-Collis, MSW, LCSW**

Phyllis Haas, LMSW

Topic Lead	**Renée Bova-Collis, MSW, LCSW**
Topic	Patient and Family Engagement
Network Goals	• Achieve a 30% increase in the number of facilities that successfully integrate patients and families into QAPI meetings. • Achieve a 30% increase in the number of facilities that successfully assist patients to develop a life plan, from which the dialysis facility develops the dialysis plan of care. • Achieve a 15% increase in the number of facilities that successfully develop and support a peer-mentoring program.
Facility Responsibilities	• Report patient attendance in QAPI using online link found on PFE page under Ongoing Projects tab: https://esrdqiaforms.qualityinsights.org/nw5/epic2021/create • Notify Renée of any month in which a care plan includes a patient self-directed goal. • Use mentor/mentee form to refer patients to peer mentor program (found on PFE page under Ongoing Projects tab.) • DO NOT EMAIL PII OR PHI

Patient and Family Engagement – OP1

- DaVita Falls Road
- Westhampton Dialysis
- UVA Farmville
- FKC Broad Street
- Livingston Village

Metric	Baseline	Goal	Re-Measurement	Goal Achieved
Include patients in QAPI	4	10%	39	Yes
Assist patients to develop a Life Plan	5	10%	61	Yes
Develop and supporting a Peer Mentoring Program	1	5%	18	Yes

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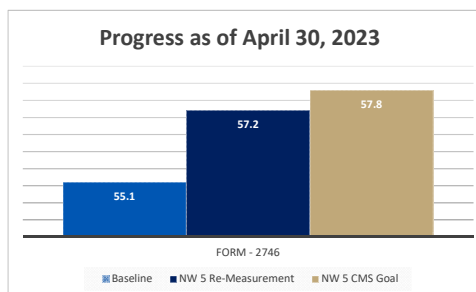|	
Topic Lead	**Phyllis Haas, LMSW**
Topic	Grievances and IVDs
Network Responsibilities	• Keep communications open between patients and dialysis facility staff on issues, problems, or grievances • Ensure problems are solved as quickly as possible • Help patients feel comfortable taking their concerns to an appropriate authority without fear of mistreatment or retaliation • Refer to an appropriate agency when needed • Monitor for compliance with the Conditions for Coverage
Facility Responsibilities	• Cooperate with Network investigations • Provide staff training on professionalism utilizing resources found on the QIRN5 website. • Provide staff training on dealing with difficult patient situations by utilizing resources found on the QIRN5 website. • Actively consult with the Network regarding difficult patient situations, including adherence and disruptive behaviors prior to any situation escalating to the consideration of an IVD. • Display the Network grievance poster in an area easily viewed by all patients. Include state survey's contact information and internal grievance process. • Complete "Avoiding IVD" training for social workers – Coming soon! • DO NOT EMAIL PII OR PHI

Data Specialist

Alison Crittenden

Topic Lead	**Alison Crittenden**
Topic	Data Quality
Network Goals	• Achieve a 1% increase in the number of incomplete initial CMS-2728 forms that are over one-year-old, that are completed and submitted. • Achieve a 4% increase in the rate of initial CMS-2728 forms submitted from dialysis facilities within 45 days. • Achieve a 9% increase in the rate of CMS-2746 forms submitted from dialysis facilities within 14 days of the date of death. • Goals to be achieved by April 30, 2024
Facility Responsibilities	• Identify at least two staff members who have access to EQRS. • Enter all admissions into EQRS within 5 days and adhere to all other EQRS Data Management Guidelines. • Monitor EQRS dashboard daily for missing forms, forms that are due soon and forms that are past due • Call the Network Data Department (Alison, Ext. 2707) right away if you need assistance admitting patients or completing forms in EQRS. • Hit SUBMIT! Saved forms are not considered submitted.

Data Quality – OP1

- Renal Care Group – Danville
- DaVita Dulaney Towson
- DaVita Radford
- DaVita Virginia Beach
- UVA Augusta

Progress as of April 30, 2023

| | 55.1 | 57.2 | 57.8 |

FORM - 2746

Baseline   NW 5 Re-Measurement   NW 5 CMS Goal

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Health Equity Specialist

Andrea Moore, LMSW

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Topic Lead	Andrea Moore, LMSW
Topic	Health Equity
Network Responsibilities	• Develop and deploy interventions and activities aimed at reducing identified health disparities • Assist facilities with embedding Culturally and Linguistically Appropriate Services (CLAS) into the delivery of care • Maintain and spread training resources that promote health literacy, health equity, and the consistent development of health literate materials • Expand partnerships with community-based organization to identify social determinant of health needs among the dialysis population and co-develop strategies to meet needs

Facility Responsibilities	• Implement appropriate CLAS Standards
	  • Engage with 2 video-based resources
	  • Utilize CLAS checklist to assess current implementation of the National CLAS Standards
	• Perform a Health Literate Materials Audit
	  • Audit the lobby bulletin board and other "patient news" areas throughout the clinic examining areas for materials that do not meet criteria for "health literate material"

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Health Equity - Tips

- Become familiar with the Network's Health Equity Hub for relevant trainings (FREE CEs), tools and resources, and health-equity related data - https://www.qualityinsights.org/qirn5/health-equity
- To learn more about what makes materials health literate review: Developing Health Literate Materials: A How-to Guide
- 2 CLAS Videos
  - MICROLEARN: What are Culturally and Linguistically Appropriate Services?
  - MICROLEARN: Using Culturally and Linguistically Appropriate Services to Improve Delivery of Care

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Opportunities for Collaboration

- Quarterly Virtual Council Meetings
  - All are invited
  - Share data, updates, best practices
- Engage in Quality Improvement Activities
  - Cohorts, high opportunity, high priority
  - Focus on patient & family engagement, health equity
- On-site Technical Assistance
  - 25% of facilities will receive on-site technical assistance from Network staff, already been notified
- Participate in Coalitions
  - High performers, share best practices, offer solutions

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Network Expectations

- Engage
  - Respond to inquiries and request for information
  - Take action
  - Sign up and read electronic newsletter, e-Lerts
- Notify the Network of major events
  - Facility emergencies/closures
  - Leadership/staff changes
- Inform patients of available Network resources
  - Grievance resolution
  - Educational materials
  - Patient & Family Advisory Committee
- Pursue Network Goals
  - Participate in Network Quality Improvement Activities (QIAs)
  - Engage in Network facilitated technical assistance
  - Monthly, monitor progress utilizing the ESRD Facility Report, discuss and document in QAPI meetings

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Network Monitoring

- Facility engagement
  - Communication
  - Responsiveness
  - Timeliness
  - Effort
- Facility performance
  - Goal achievement
  - Progress towards goal achievement

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ESRD Facility Report

- https://esrdreportsnw5.qualityinsights.org/
- Each facility has a unique Username and Password
- Usernames and passwords remain the same and will be distributed via email to Facility Administrators, Social Workers, and Medical Directors every month
- Needs to be accessed monthly
  - Will be monitored

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Consequences

- Performance Improvement Plans
  - Including oversight by CMS and State Survey Agency
- Referral to State Survey Agency
  - Failure to adhere to Conditions for Coverage
- Recommend Sanctions
  - Identify facilities that have consistently failed to cooperate with Network goals

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Key Takeaways

- **ALL** facilities are required to be working towards **ALL** goals (exception: incident home, telemedicine, NH)
- Individual projects may focus on a few specific goals, but this does not disqualify a facility from making progress on the others
- Engage with the Network – the CfC require it!

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Outreach Coordinator

Heather Cecil

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Next Steps

Complete Facility Personnel Update:
- Provide Current Facility Personnel Coming week of June 5, 2023!

Gain Access to EQRS:
- At LEAST two (three is best) staff members in each facility with access
  - https://beacon.by/quality-insights/harp-quick-start-guide

Access ESRD Facility Report:
- Facility specific data, updated monthly
  - Username and passwords will be distributed to FA, SW, MD monthly
  - https://esrdreportsnw5.qualityinsights.org/

Register for e-lerts
- Electronic newsletter distributed twice a month
  - https://www.qualityinsights.org/qirn5/about/elerts

Include "What is the Network" in new staff orientation
- Video available on website
  - https://www.youtube.com/watch?v=M-TdR-QJCwo

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Thank you!