



SERVING THE ESRD COMMUNITY IN GEORGIA, NORTH CAROLINA, AND SOUTH CAROLINA



End-Stage Renal Disease
Network of the South Atlantic

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Provider Insider

AN ELECTRONIC NEWSLETTER FOR RENAL CARE PROFESSIONALS

Quick Links

[Extension of NHSN Third-Quarter 2017 Deadline](#)
[Statement of Work](#)

[2018 ESRD Network Statement of Work](#)

[Understanding 2018 ESRD QIP](#)

[CDC Making Dialysis Safer for Patients Coalition](#)

[Learning & Action Networks](#)

[Identifying and Addressing Barriers for ESRD Beneficiaries](#)

[NHSN Dialysis Event Surveillance Instructions](#)

[KCER Alerts and Information](#)

IPRO ESRD Program

[Click here](#) to learn more about the IPRO ESRD Networks (1, 2, 6 & 9).

Extension of NHSN Third-Quarter 2017 Deadline for ESRD QIP

After the Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN) system release on December 2, 2017, analysis reports and select alerts were not accessible to some NHSN Dialysis Component group and facility users. This issue has since been resolved, and users are now able to access their reports and receive alerts.

As a result of this issue, outpatient dialysis facilities and groups were unable to review NHSN data for completion and accuracy from December 2, 2017 through December 21, 2017. To provide facilities with ample time to review their NHSN data and make any corrections, CMS has extended the ESRD QIP deadline for facilities to enter third-quarter 2017 NHSN data to January 31, 2018.

For more information on the ESRD QIP, please visit <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/index.html>.

For more information about NHSN, please visit <https://www.cdc.gov/nhsn/dialysis/>.

Thank you for your attention in this matter and for entering your facility's data promptly. If you have any additional questions or concerns, please contact the NHSN helpdesk at NHSN@cdc.gov or CMS ESRD QIP team at esrdqip@cms.hhs.gov.



A Snapshot of the 2018 ESRD Network Statement of Work - What it Means to Your Facility

In October 2017 ESRD Networks received a new statement of work (SOW) from the Centers for Medicare & Medicaid Services (CMS). This document outlines the quality improvement activities (QIAs) that each Network is required to implement within its service area during 2018. This new SOW includes many changes to the requirements of the previous SOW. While the number of QIAs reduced from eight to four, the scope of the QIAs expanded significantly:

The number of facilities required to participate in QIAs has increased; this increase, in turn, significantly expands the number of patients that will benefit from the quality improvement activities being conducted. Any facility that is working with the Network on a QIA will be required to participate in national Learning & Action Network (LAN) webinars, hosted by the ESRD National Coordinating Council (NCC) on behalf of CMS (See article in this issue, "Facility Involvement in Learning & Action Networks: A 2018 CMS Requirement"). The QIAs are patient centered, and each participating facility is encouraged to have patients work hand-in-hand with management and the facility's QAPI teams to ensure the success of the QIA's goals. A brief description of each QIA, its scope, and the CMS goals follow.

Reduce Rates of Bloodstream Infections (BSI)

Fifty percent of the Network's facilities, those with the lowest semi-annual pooled mean rates of BSI, will participate in the BSI QIA. Staff at these facilities will receive education and training on implementation of the CDC Core interventions and will be invited to the NCC LAN BSI events. Those facilities selected for participation in this QIA will be subdivided into three intervention cohorts, each of which will have different focused goals, activities, and measures of success. Network staff will work with each of these cohorts on specific quality improvement measures to achieve the goals of the QIA.



The graphic to the right identifies the three cohorts and the following lists the goal for each cohort:

- Each facility in the BSI cohort will work to reduce its semi-annual pooled mean rate of BSI by 20%.
- Facilities in the Long-term Catheter (LTC) cohort will work to reduce the LTC count by two percentage points.
- Facilities in the Health Information Exchange (HIE) cohort will work to participate in an HIE or in some other evidence-based effective information transfer system.

Improve Transplant Coordination

This year Network staff will work with 30% of the facilities in our service area to increase, by 10 percentage points over baseline, the number of eligible patients on the transplant waitlist. Network staff will work with transplant centers and in-center facilities to meet this goal. Network staff will work with facilities to monitor patient progress using the *Seven Steps to Waitlist* Process outlined in the table to the right.

Seven Steps to Waitlist

- Patient Suitability
- Patient Interest
- Referral to Transplant Center
- First Visit to Transplant Center
- Transplant Work up
- Successful Transplant Candidate
- Waitlist / Evaluation of Living Donation

Promote Appropriate Home Dialysis

The Network staff will work with 30% of the facilities in its service area to increase the number of patients trained in a home modality. The goal is to increase the initiation of home training by 10 percentage points over baseline. In collaboration with physicians and in-center staff, Network staff will work to create a culture of "home first." Network staff will work with facilities to monitor patient progress toward the goal of initiating home training

using the *Seven Steps to Home Modality Training* as outlined in the table to the right.

Seven Steps to Home Modality Training

- Patient Interest
- Education to Determine Patient Preference
- Suitability Determined by Nephrologist
- Assessment for Access Placement
- Placement of Access
- Patient Acceptance into Program
- Initiation of Training

Population Health Focused Pilot QIA (PHFPQ): Vocational Rehabilitation

For the PHFP QIA, the Network will focus on supporting ESRD patients in attaining gainful employment through vocational rehabilitation. Working with 10% of the dialysis facilities in its service area, the Network will seek to increase referrals to approved vocational rehabilitation programs by 5%, with the ultimate goal of increasing in enrollment in vocational rehabilitation services by 2% from baseline to re-measure. Additionally, Network staff will identify a disparity within the target facilities and work with the targeted population to decrease the gap in services.



Understanding the 2018 End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP)

CMS implemented the ESRD QIP in 2012 to help ensure that high quality healthcare is provided to all ESRD patients by incentivizing dialysis facilities through pay-for-performance based on the quality of care they deliver. There are 16 measurements for the 2018 calendar year (CY), which will reflect in the 2020 payment year (PY). These measures should be reviewed monthly and discussed with the healthcare team at QAPI meetings. Measures are separated into the following three components:

Clinical:

- * ICH CAHPS
- * Standardized Readmission Ratio
- * Kt/V Dialysis Adequacy (comprehensive)
- * Standardized Transfusion Ratio
- * VAT Measure Topic (fistula, catheter)
- * Hypercalcemia
- * Standardized Hospitalization Ratio



Safety:

- * NHSN BSI Measure Topic (NHSN BSI clinical, Dialysis Event reporting)

Reporting:

- * Serum Phosphorus
- * Anemia Management
- * Pain Assessment and Follow-Up
- * Clinical Depression Screening and Follow-Up
- * NHSN Healthcare Personnel Influenza Vaccination
- * Ultrafiltration Rate

Additional information about the ESRD QIP:

- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/index.html>
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/Downloads/ESRD-QIP-Summary-Payment-Years-2016---2020.pdf>
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/ESRDQIP/061_TechnicalSpecifications.html

Network staff members are available to assist facility staff in overcoming any barriers in achieving these measures.



CDC Making Dialysis Safer for Patients Coalition

The Making Dialysis Safer for Patients Coalition is a partnership of organizations and individuals that have joined forces with the common goal of promoting the use of the Centers for Disease Control and Prevention's (CDC) core interventions and resources to prevent dialysis bloodstream infections. CDC's core interventions have been proven to reduce the number of infections by half and be sustainable. The CDC has also developed a set of audit tools, checklists, and other resources to help facilitate adoption of these critical core interventions.



The IPRO ESRD Network Program is pleased to announce that we have now joined the CDC Making Dialysis Safer for Patients Coalition.

To learn more about the Coalition and how to become a [partner](#) or [member](#) please visit: <https://www.cdc.gov/dialysis/coalition/index.html>.



Facility Involvement in Learning & Action Networks: A 2018 CMS Requirement



All facilities participating in Network QIAs are required to participate in national Learning & Action Networks (LANs) to support QIA activities. LANs provide a forum for bringing together healthcare professionals, patients, and other stakeholders around an evidence-based agenda to achieve rapid, wide-scale improvement.

Staff members at facilities participating in QIAs will be asked to participate in ESRD National Coordinating Center (NCC) LAN webinars associated with the QIA their facility is working on. The Network may also select additional facilities that may benefit from an identified LAN topic. Patients and their family/caregivers will also be asked to participate in an effort to advance the work of the QIA.

The ESRD NCC LAN will support facilities in more efficiently achieving the goals of the QIAs and sustaining the improvements, by:

- Creating a diverse forum (patients, organizations, and stakeholders) for addressing problematic issues
- Using measurable and clear goals with proven effective practices to drive decision making
- Setting the pace and tone for goal related activities and to create an open sharing of practice and data
- Initiating change methodology which rapidly tests small quality improvement changes specific to the area of work

Patient Services

Identifying and Addressing Barriers for ESRD Beneficiaries

A 2013 study on the ESRD beneficiary grievance process, The ESRD Beneficiary Grievance Process (OEI-01-11-00550) conducted by the U.S. Health and Human Services, identified deficiencies at facilities across the country. Because of this study, the following five recommendations for improvement were made to CMS: 1) define "grievance" for facilities, 2) require that facilities report grievances regularly to their respective networks, 3) provide guidance to facilities on what constitutes a robust process for anonymous grievances, 4) work with the Agency for Healthcare Research and Quality to add a question to the standardized



satisfaction survey to assess ESRD beneficiaries' fear of reprisal, and 5) provide networks with better technical support for their grievance database. Of these recommendations CMS is working to address barriers related to the definition of a grievance, what constitutes a robust process for anonymous grievances, and providing better technical support for the grievance database. It is important for patients to be able to file a grievance without fear of reprisal. In order to reduce the fear of reprisal, all facilities must develop an anonymous internal grievance process that allows patients, family members, or caregivers to voice their concerns. According to CMS guidelines, in an anonymous grievance, the identity of the person(s) will remain unknown to the facility. Patients should be

educated that the facility is unable to contact an anonymous grievant to inform them of the steps taken to investigate the grievance or the outcome of the investigation. In these cases, the grievant should be advised of the following:

- The grievance will be investigated, but the facility will be unable to report back to them, unless a name and address is provided.
- Because of the small population in dialysis facilities, the provider involved may be able to identify the grievant, even when anonymity is maintained.
- The investigation may be limited due to minimal amount of information available to the facility.

Data Management

NHSN Dialysis Event Surveillance Instructions for Acute Kidney Injury (AKI) Patients

Beginning January 1, 2018, dialysis facilities should include acute kidney injury (AKI) patients in National Healthcare Safety Network (NHSN) Dialysis Event Surveillance. Reporting AKI patient data to a new, separate NHSN location will enable CDC to exclude AKI patient data from NHSN Bloodstream Infection (BSI) information shared with CMS for purposes of the ESRD Quality Incentive Program (QIP).



The "Acute Kidney Injury (AKI) Location" should be used to report Dialysis Events, and denominator data for patients who have acute kidney injury and do not have an end-stage renal disease (ESRD) diagnosis at the time of the Event, or at time of denominator data collection.

The "Acute Kidney Injury Location" was released as part of the NHSN version 8.8 update on December 2, 2017. Please click [here](#) for instructions on using the "Acute Kidney Injury Location".

Of those included in the NHSN Dialysis Event Surveillance population, the following criteria should be used to identify patients who have acute kidney injury:

1. No diagnosis of "End Stage Renal Disease" or "ESRD" in the patient medical record, or through the ESRD Medical Evidence Form (Form CMS-2728-U3).
AND
2. Physician-diagnosis of "Acute Kidney Injury: or "AKI" listed in the patient medical record (e.g., nephrologist consult or referral form). AND
3. The event date, or date of denominator data collection, is not more than 6 months after the date the patient initiated outpatient hemodialysis.

For questions, please contact the NHSN helpdesk: nhsn@cdc.gov with "dialysis" in the subject line.



Kidney Community Emergency Response (KCER) Alerts and Information

- Click [here](#) for up-to-date KCER Alerts and Recalls.
- For professional and patient KCER resources, please click [here](#).



**Kidney Community
Emergency Response**



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Stay Connected

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