HSAG HEALTH SERVICES ADVISORY GROUP

ESRD Networks 7, 13, 15, 17, 18

Continuous Quality Improvement: An ESRD Network 7 Update

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March 13, 2023

Disclosure

- Nothing to disclose

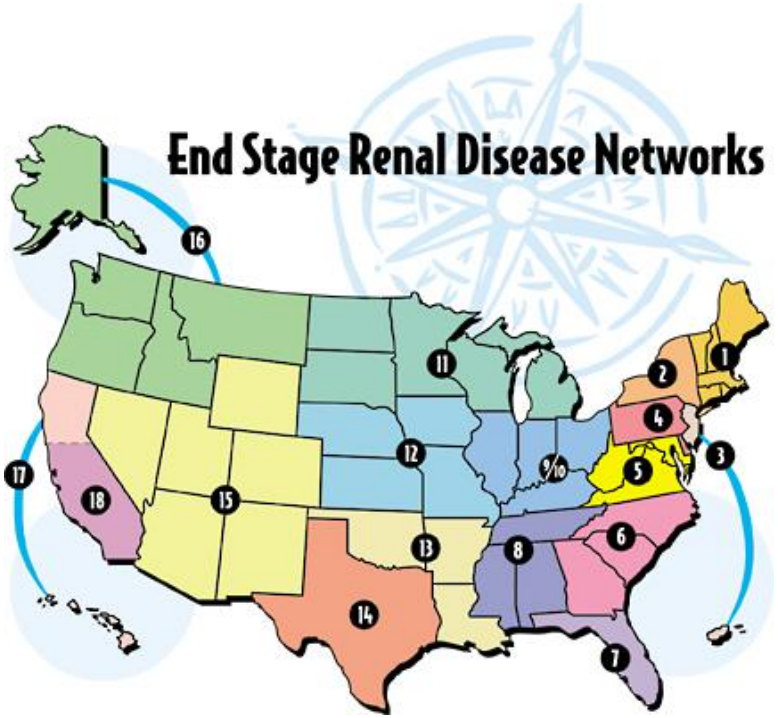
Learning Points

- Discuss Health Equity as a focus for quality improvement work.
  - Change Package
- Explore the 2021-2026 Network quality improvement projects and goals.
- Review the Facility Scorecard as a tool for quality improvement
- Network reminders

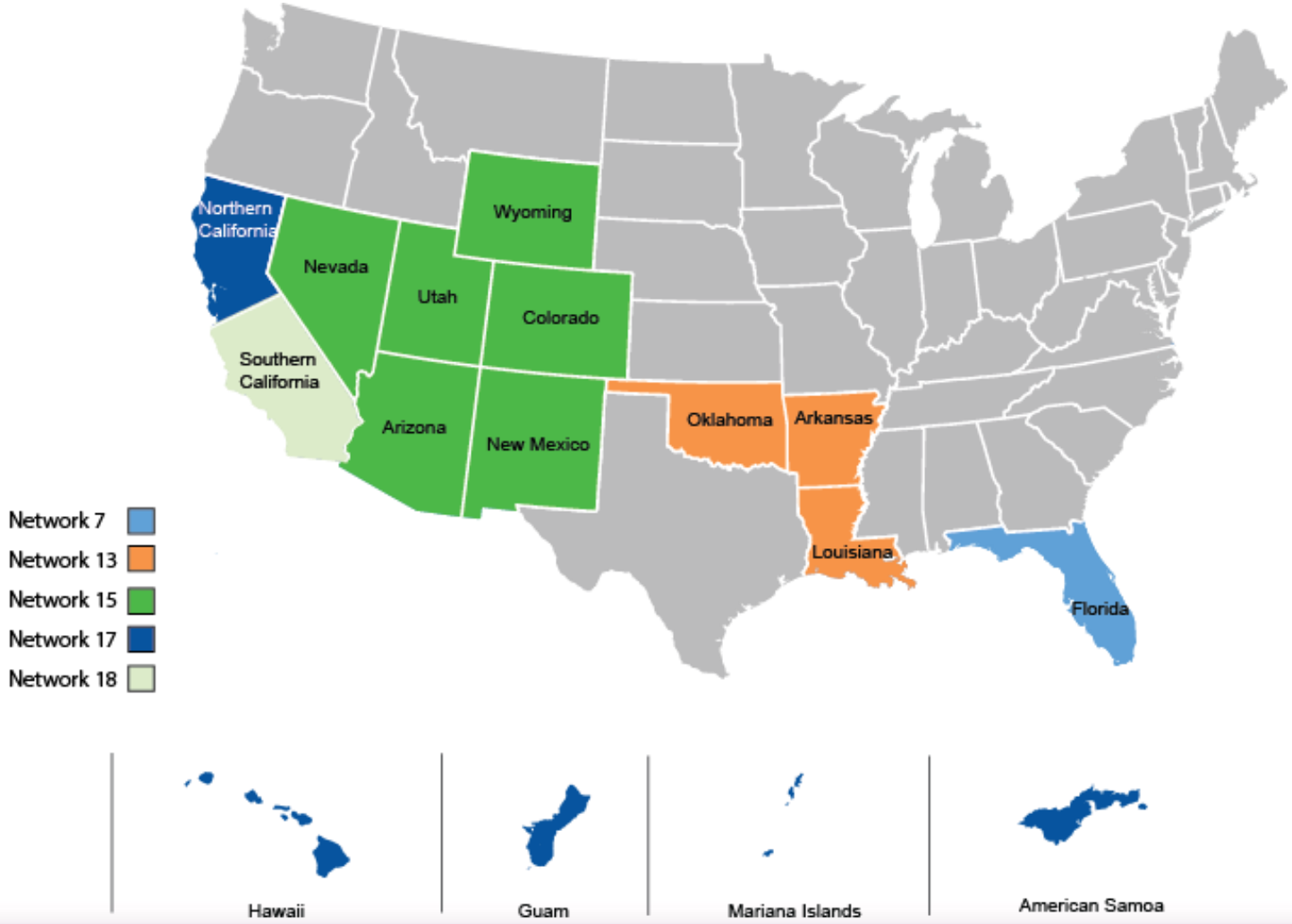
Role of the ESRD Network

Centers for Medicare & Medicaid Services (CMS) Goals for Networks:

- Increase focus on patient-centered care
- Improve quality and safety of care
- Improve independence, quality of life, and rehabilitation
- Resolve grievances and improve patient perception and experience of care
- Increase collaboration with providers
- Improve collection, reliability, timeliness, and use of data



The HSAG ESRD Networks



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Health Equity Review

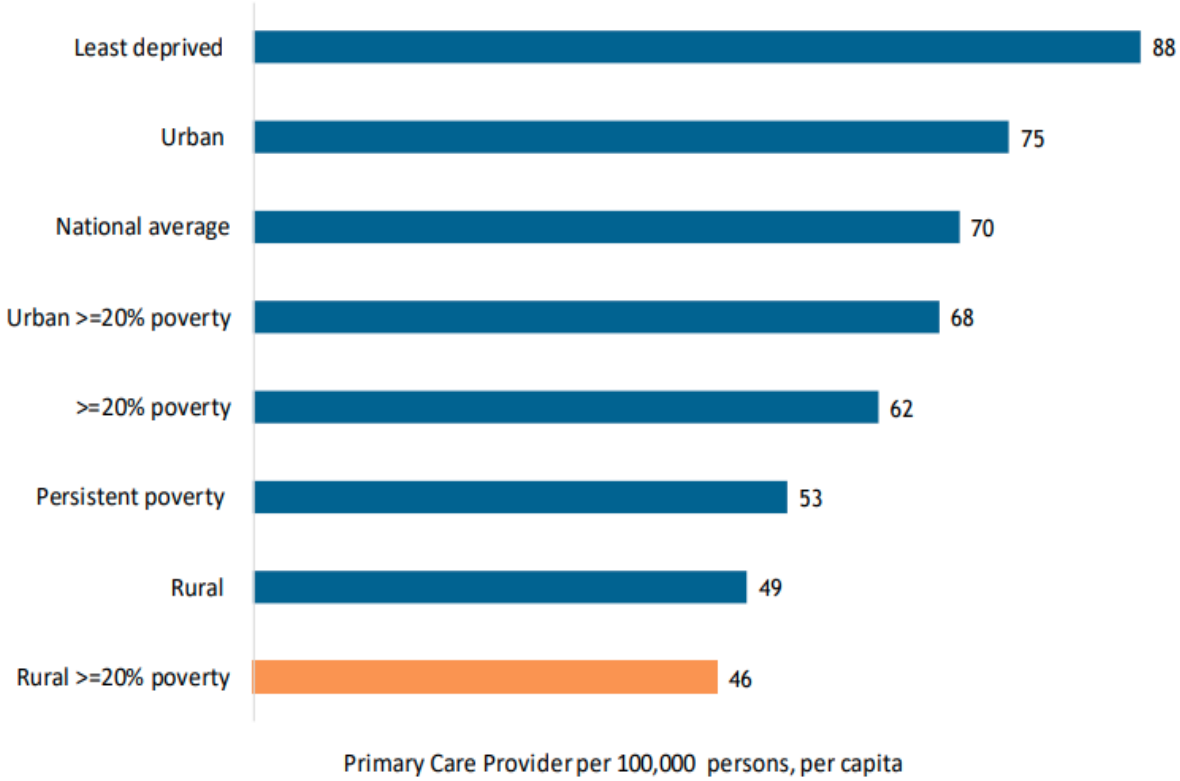
Health Equity

- The Network has been tasked with implementing QIAs that also focus on mitigating Health Equity issues.
- Centers for Medicare & Medicaid Services (CMS) states that "Health Equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances."
- CMS Framework for Health Equity 2022 - 2032


Priority 1:
Expand the Collection, Reporting, and Analysis of Standardized Data
Priority 2:
Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps
CMS Framework for Health Equity Priorities
Priority 5:
Increase All Forms of Accessibility to Health Care Services and Coverage
Priority 3:
Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities
Priority 4:
Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

Access to Healthcare

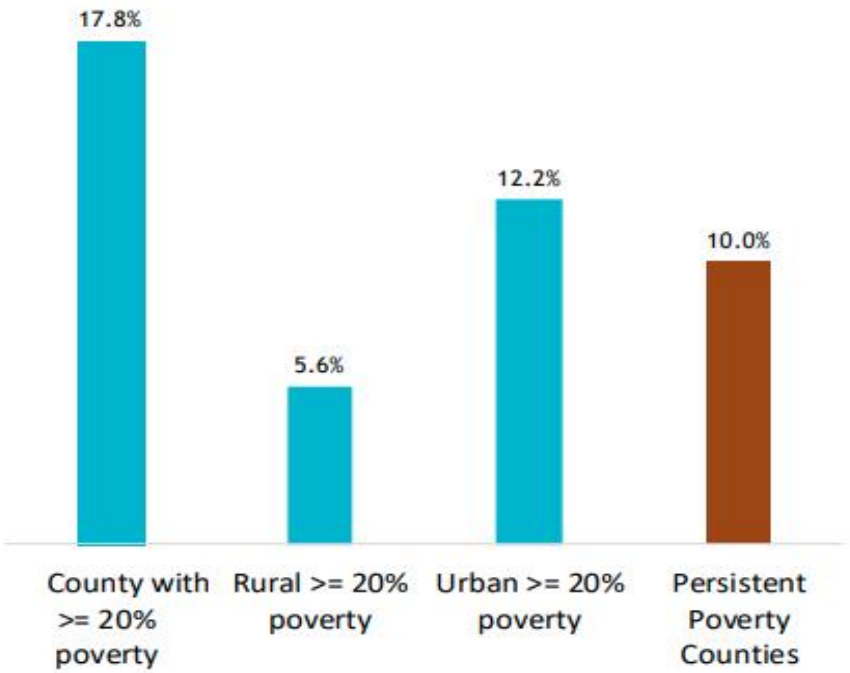
Access to primary care provider among ESRD patients is lower in rural areas, and lowest among rural areas with high poverty

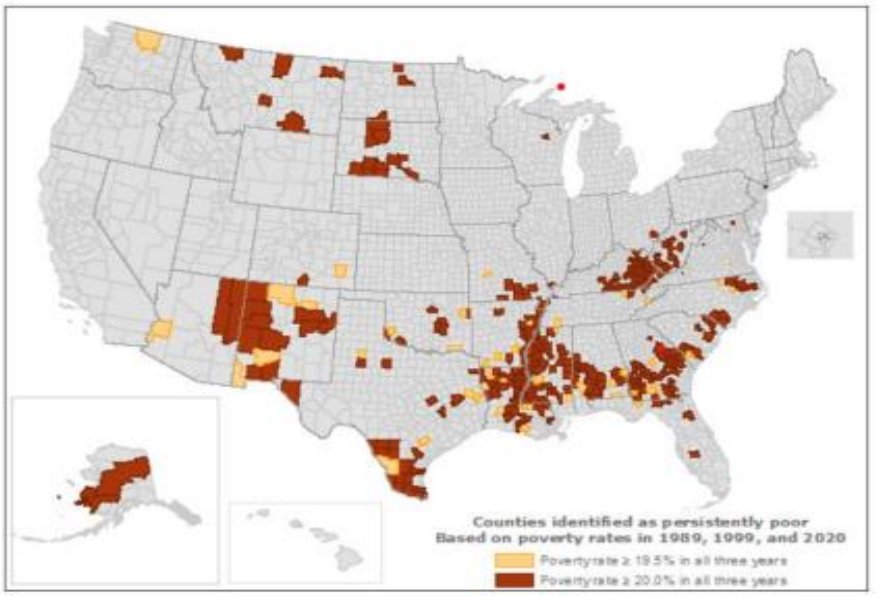


Source: Data were obtained from the Federal Communications Commission and linked with ESRD patient records. FIPS codes were used to perform the data linkage. A total of 347,637 matched patients.
Note. These categories are not mutually exclusive.

Socioeconomic Factors

17% of ESRD Patients live in high poverty counties



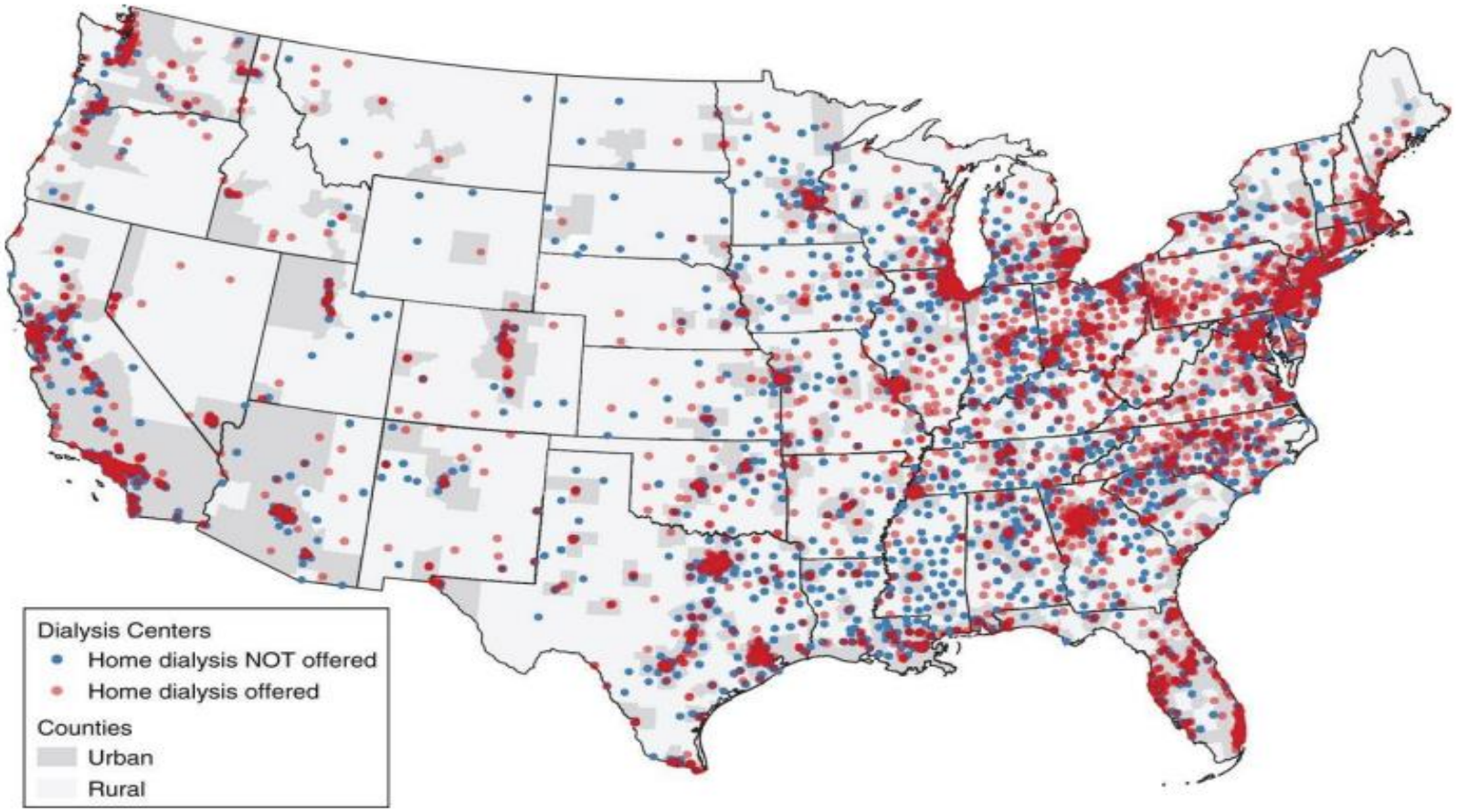


Persistent Poverty Counties Based on US Census Bureau 1990, 2000, 2020

Source: Data were obtained from the Federal Communications Commission and linked with ESRD patient records. FIPS codes were used to perform the data linkage. A total of 347,637 matched patients.
Figure created by Congressional Research Service using data from the U.S. Census Bureau

Access to Healthcare

Rural dialysis facilities were less likely to offer home dialysis



Source: Adler, J. T., Husain, S. A., Xiang, L., Rodrigue, J. R., & Waikar, S. S. (2022). doi:10.34067/KID.0006932021

Health Equity Resources (ESRD NCC)

Access to Primary Care Provider Among End-Stage Renal Disease Patients

Influence of the Social Determinants of Health on Access to Healthcare Services

Primary care providers (PCPs) are needed in several areas of care for chronic kidney disease (CKD) populations, including helping to identify and manage patients at risk for CKD before diagnosis is established.[1] PCPs perform screening for CKD and are vital in the care of patients with early stages of CKD. A previous study reported that rural dialysis patients have less pre- End-Stage Renal Disease (ESRD) dietary care compared to urban patients.[2] A national analysis documented that the average state-level probability of having received nephrologist care was 28.8%, and concluded that patients were more likely to receive pre-dialysis nephrologist care in state with higher socioeconomic status.[3] This report investigated access to primary care providers among ESRD patients, and compared disadvantage areas to identify gaps in care access.

Data Source

Data were obtained from the Federal Communications Commission[4] and linked with ESRD patient records vis FIPS codes. There was a total of 347,637 matched patient records

Urban-Rural Difference

Access to primary care provider is significantly higher among ESRD patients in urban areas compared to those in rural areas.

On a per capita basis, there were about 70 primary care providers per 100,000 persons nationally. Among ESRD patients living in urban areas, there was an average 75 PCPs per 100,000 persons, compared to that of 49 PCPs in rural areas.

Higher percent of ESRD patients in rural areas were living in high poverty neighborhoods, compared to patients living in urban areas. 15.0 % of ESRD patients live in rural areas (n = 52,275). Among this population, 37.2% lived in areas with greater than 20 percent poverty, whereas 14.3% of urban ESRD patients lived in high poverty counties.

Table 1. Number of Primary Care Provider Per Capita among ESRD Patients, 2022

	Primary Care Provider Per 100,000 persons	Percent of ESRD patients
Urban-Rural		
Urban	75	85.0%
Rural	49	15.0%
Socioeconomic Status		
County with ≥ 20% poverty	62	17.8%
Rural ≥ 20% poverty	46	5.6%
Urban ≥ 20% poverty	68	12.2%
Persistent Poverty Counties	53	10.0%
Least deprived neighborhoods	88	18.5%

Poverty and Access to Care

The number of primary care providers serving ESRD patients is lower in counties of high poverty.

17.8% ESRD patients reside in counties with more than 20 percent of poverty (n = 61,907). Among these patients, there is an average of 62 PCPs per 100,000 persons, 68 PCPs in the urban most deprived area, 46 PCPs in rural areas with more than 20 percent poverty.

10.0% of ESRD patients live in counties of persistent poverty (defined as 20 percent or more of their populations living in poverty over the 30-year period using 1990, 1990, and

Health Literacy & End-Stage Renal Disease

What Is Health Literacy? Personal health literacy refers to an individual's capacity to find, understand, and use information and services to inform health-related decision and actions for themselves and others[1].

About 25% chronic kidney disease patients experience limited health literacy[2]

What Does That Mean for ESRD Patients? Examples of health literacy include understanding instructions (e.g., how to wash vascular access) and dialysis procedures (e.g., cannulation), reading education materials, understanding disease process and laboratory values, filling out forms, and the ability to navigate the complex healthcare system that is required for chronic kidney disease care. ESRD patients need to know where to get reliable information (e.g., ESRD NCC) and be able to understand it. Yet, patients often don't recognize that they lack the skills, complicated by stigma associated with it and may ask fewer questions[3].

Vulnerable populations include elderly patients, people with lower socioeconomic status or education, people with limited English proficiency

Who Is Affected by Limited Health Literacy Skills? Nearly 90 million adults in the U.S. struggle with health literacy. Even people with high literacy skills may have low health literacy skills in certain situations.

About 44% of End-Stage Renal Disease (ESRD) patients age 65 or above*

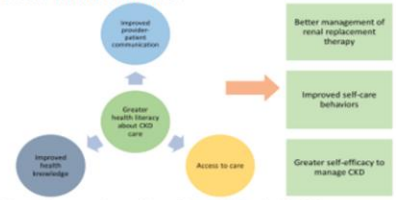
Around 65,000 ESRD patients (14%) currently live in the top 10% of socioeconomic disadvantaged areas*

Why Is Health Literacy Important in Kidney Disease Care?

People with limited health literacy skills are more likely to have worse health outcomes in a variety of chronic conditions[4], including increased mortality in ESRD[5]. Low health literacy could lead to:

- Mismanaging medication
- Needing emergency and hospital services more often, and longer stay

Greater health literacy about kidney disease (e.g., understanding of terminology) could lead to better access to care, thus often result in better health outcomes.



Note. Concept adapted from Devraj & Gordon[6]; CKD, chronic kidney disease

Strategies to Improve Health Literacy

There is a need to assess and enhance organizational health literacy within care settings and share health literacy best practices. Examples include: Avoiding jargon, encourage questions-asking, provide materials in other languages, using teach-back, tailoring patient information to the individual's experience and cultural background.

References

1. U.S. Department of Health and Human Services. Healthy People 2030.
2. Taylor et al. A systematic review of the prevalence and associations of limited health literacy in CKD. DOI:10.2215/cjn.12921216
3. Mackert et al. Stigma and health literacy: An agenda for advancing research and practice. DOI:10.5993/ajhb.38.5.6.
4. Berkman et al. Low health literacy and health outcomes: an updated systematic review. DOI: 10.7326/0003-4819-155-2-201107190-00005
5. Cavanaugh et al. Low health literacy associates with increased mortality in ESRD. DOI:10.1681/asn.2009111163.
6. Devraj & Gordon. Health literacy and kidney disease: toward a new line of research. DOI:10.1053/j.ajkd.2008.12.028

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Addressing Health Equity at the Facility Level

- Resource: *Guide to Reducing Disparities in Readmissions*
  - Key topics include:
    - Care Transitions
    - Linkage to Primary Care
    - Language Barriers
    - Health Literacy
    - Culturally Competent Patient Education
    - Social Determinants
    - Mental Health
    - Comorbidities

Network Level Quality Improvement Goals and Status

QI Activity Elements

- Option Period 1 (OP1): May 1, 2022 – April 30, 2023
- Health Equity
- Advisory Committee
  - Includes volunteer, empowered patients, providers, practitioners, and stakeholders
  - Role: Plan, develop, and implement quality improvement (QI) concepts and strategies
- Coalition
  - Includes high-performing experts and focus group facilities
  - Four-month plan-do-study-act (PDSA) cycles to address local issues
- Technical Assistance
  - Low-performers
  - Data-driven
  - QIA focus facilities are included

Home Dialysis Metrics (May 2022 – Jan. 2023)

Metric	Goal Count	Jan. 2023 Count
Incident ESRD patients starting dialysis using a home modality	1,403	981 70% towards goal 14.1% of incident patients
Prevalent ESRD patients moving to a home modality	1,865	1,514 81.2% towards goal 5.4% of prevalent patients
Number of **rural ESRD patients using telemedicine**	95	173 182.1% towards goal 72.4% of rural home patients

Home Dialysis Best Practices

- Ensure collaboration between the home programs and in center facilities for continuity of patient care.
- Include an "All Team" approach to educating staff and then patients and discuss progress during the monthly QAPI meetings.
- Use the ESRD NCC Home Change Package as a guide to interventions to mitigate facility barriers.
- Identify home dialysis patient peer mentors.
- Engage and educate Nephrologists to increase patient referrals to home.
- Utilize a tracker to monitor patients through the steps to home training.
- Use the home dialysis patient videos for peer to peer messaging found on the Home Dialysis Central website.

Transplant Metrics (May 2022 – Jan. 2023)

Metric	Goal Count	Jan. 2023 Count
Patients added to a kidney transplant waiting list	1,481	1,590 107.4% towards goal
Patients receiving a kidney transplant	1,299	1,061 81.7% towards goal

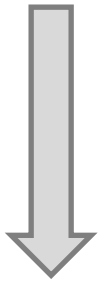
Transplant Best Practices

- Develop a process for ongoing communication with patients and staff to demystify and normalize the idea of transplant.
- Facilitate engagement between transplant mentors and patients to increase patient interest in transplant and motivate patients to follow through with the process of referral and evaluation.
- Involve the whole team in educating and supporting patients during their journey to manage issues and provide encouragement during the long process of waitlisting and staying prepared for transplant.
- Create a transplant education board in the facility's lobby that includes rotating information on the benefits/risks of transplant, transplant requirements, insurance/financial items, and how the transplant process works.
- Develop relationships with transplant coordinators to effectively communicate and collaborate regarding patient referrals, evaluations and waitlisting.

Improving NH Care Metrics (May 2022 – Jan. 2023)

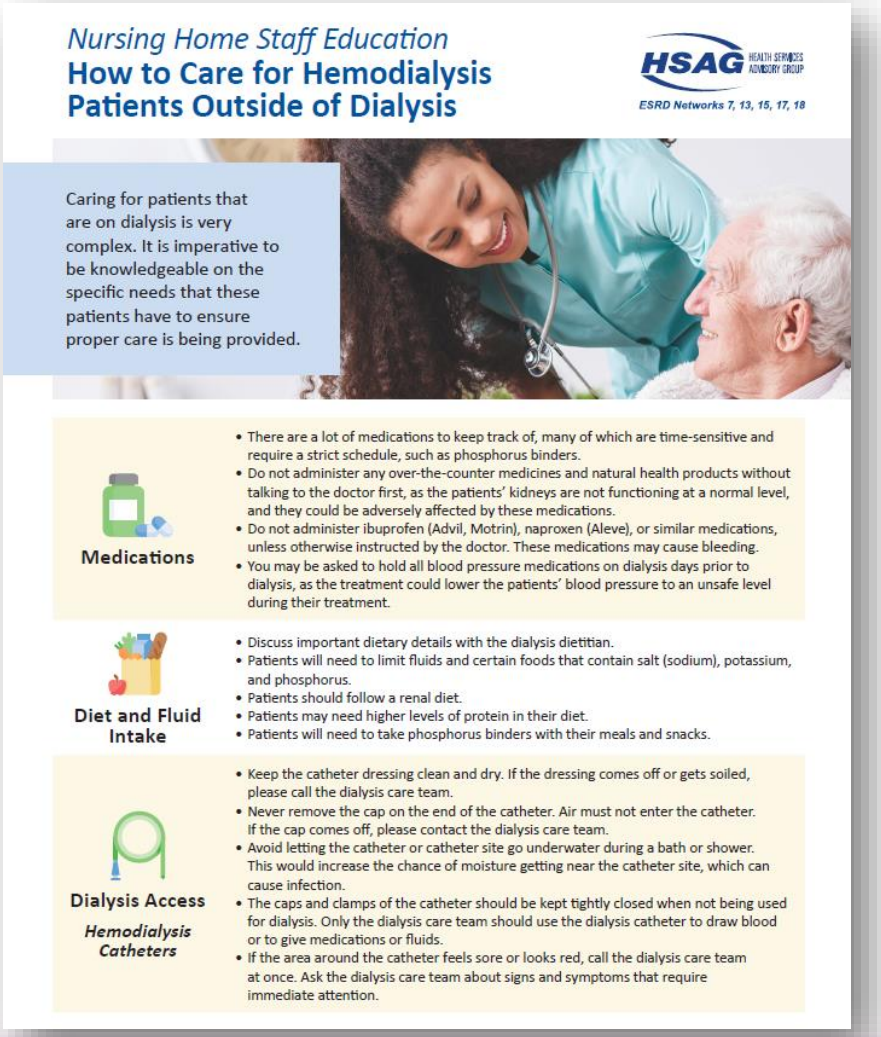
Metric	Upper Limit Rate	Jan. 2023 Rate
Decrease in the LTC infection rate for patients receiving home dialysis in a NH	1.15%	1.33%
Decrease in the incidence of peritonitis in patients receiving home dialysis in a NH	0.0%	0.0%
Decrease in the rate of patients who receive dialysis at a NH and receive a blood transfusion	10.9%	8.2%

Lower rate indicates better performance



Improving Nursing Home Care Best Practices

- Engage NH staff to:
  - Educate about dialysis catheter care.
  - Address anemia timely.
  - Track and notify regarding need for blood transfusions.
  - Review patient status weekly.



Nursing Home Staff Education

How to Care for Hemodialysis Patients Outside of Dialysis

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Caring for patients that are on dialysis is very complex. It is imperative to be knowledgeable on the specific needs that these patients have to ensure proper care is being provided.

Medications

- There are a lot of medications to keep track of, many of which are time-sensitive and require a strict schedule, such as phosphorus binders.
- Do not administer any over-the-counter medicines and natural health products without talking to the doctor first, as the patients' kidneys are not functioning at a normal level, and they could be adversely affected by these medications.
- Do not administer ibuprofen (Advil, Motrin), naproxen (Aleve), or similar medications, unless otherwise instructed by the doctor. These medications may cause bleeding.
- You may be asked to hold all blood pressure medications on dialysis days prior to dialysis, as the treatment could lower the patients' blood pressure to an unsafe level during their treatment.

Diet and Fluid Intake

- Discuss important dietary details with the dialysis dietitian.
- Patients will need to limit fluids and certain foods that contain salt (sodium), potassium, and phosphorus.
- Patients should follow a renal diet.
- Patients may need higher levels of protein in their diet.
- Patients will need to take phosphorus binders with their meals and snacks.

Dialysis Access

Hemodialysis Catheters

- Keep the catheter dressing clean and dry. If the dressing comes off or gets soiled, please call the dialysis care team.
- Never remove the cap on the end of the catheter. Air must not enter the catheter. If the cap comes off, please contact the dialysis care team.
- Avoid letting the catheter or catheter site go underwater during a bath or shower. This would increase the chance of moisture getting near the catheter site, which can cause infection.
- The caps and clamps of the catheter should be kept tightly closed when not being used for dialysis. Only the dialysis care team should use the dialysis catheter to draw blood or to give medications or fluids.
- If the area around the catheter feels sore or looks red, call the dialysis care team at once. Ask the dialysis care team about signs and symptoms that require immediate attention.

COVID-19 and Flu Vaccination Metrics (May 2022 – Jan. 2023)

Metric	Goal Rate	Jan. 2023 Rate
Dialysis patients receiving primary COVID-19 vaccination	80%	62.2%
Dialysis patients receive COVID-19 Booster	80%	55.1%
Dialysis staff vaccinated against COVID-19	100%	77.6%
Dialysis staff receive COVID-19 Booster	100%	28.2%
Dialysis patients receive an influenza vaccination	90%	74.2%
Dialysis staff receive an influenza vaccination	90%	26.7%

Pneumococcal Vaccination Metrics (May 2022 – Jan. 2023)

Metric	Goal Rate	Jan. 2023 Rate
Increase in patients that receive the pneumonia vaccine (PCV13)	65%	60.1%
Increase in patients that receive the initial PPSV23	90%	84.2%
Increase in patients that receive a PPSV23 booster	72.6%	52.0%
Increase in patients that are over 65 years of age and receive a PPSV23	85%	74.8%

Vaccination Best Practices

Vaccination resources can be found on the [HSAG ESRD Networks Vaccination](#) Webpage. Examples include:

- Vaccination Root Cause Analysis and Action Plan
- *A Change Package to Increase Vaccinations*
- *COVID-19 Vaccination Tracker*
- *Vaccination Myth Busters* handout
- *Vaccination Wallet Card*
- *Why Not Vaccinate?* patient questionnaire

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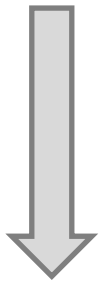
Reducing Hospitalization Admissions, Readmissions and ED Visit Metrics

Metric	Goal Rate (per 100 patient months)	Jan. 2023 Rate
Reduction in ESRD-related hospital admissions	3.65%	3.68%
Reduction in 30-day unplanned readmissions	12.2%	11.4%
Reduction in ED visits	1.54%	1.57%

Lower rate indicates better performance



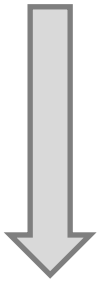
Reducing Hospitalizations Best Practices

- Be consistent about fluid management: conduct regular reviews, reschedule patients, provide education, train staff on proper weighing, adjust weights timely.
- Use a Post Hospitalization Checklist.
- Connect patients to primary care physicians.
- Perform a Five Whys analysis for each case to better understand why patients go to the hospital.
- Case manage and reeducate patients that utilize the hospital more frequently.
- Communicate with local hospital case management staff about specific patient needs.

Reduce COVID-19 Hospitalizations Metrics (May 2022 – Jan. 2023)

Metric	Goal Count (Per 100 patient months)	Jan. 2023 Count
COVID-19 Hospitalizations	1,882	1,186 (63.0% of goal count)

Lower rate indicates better performance

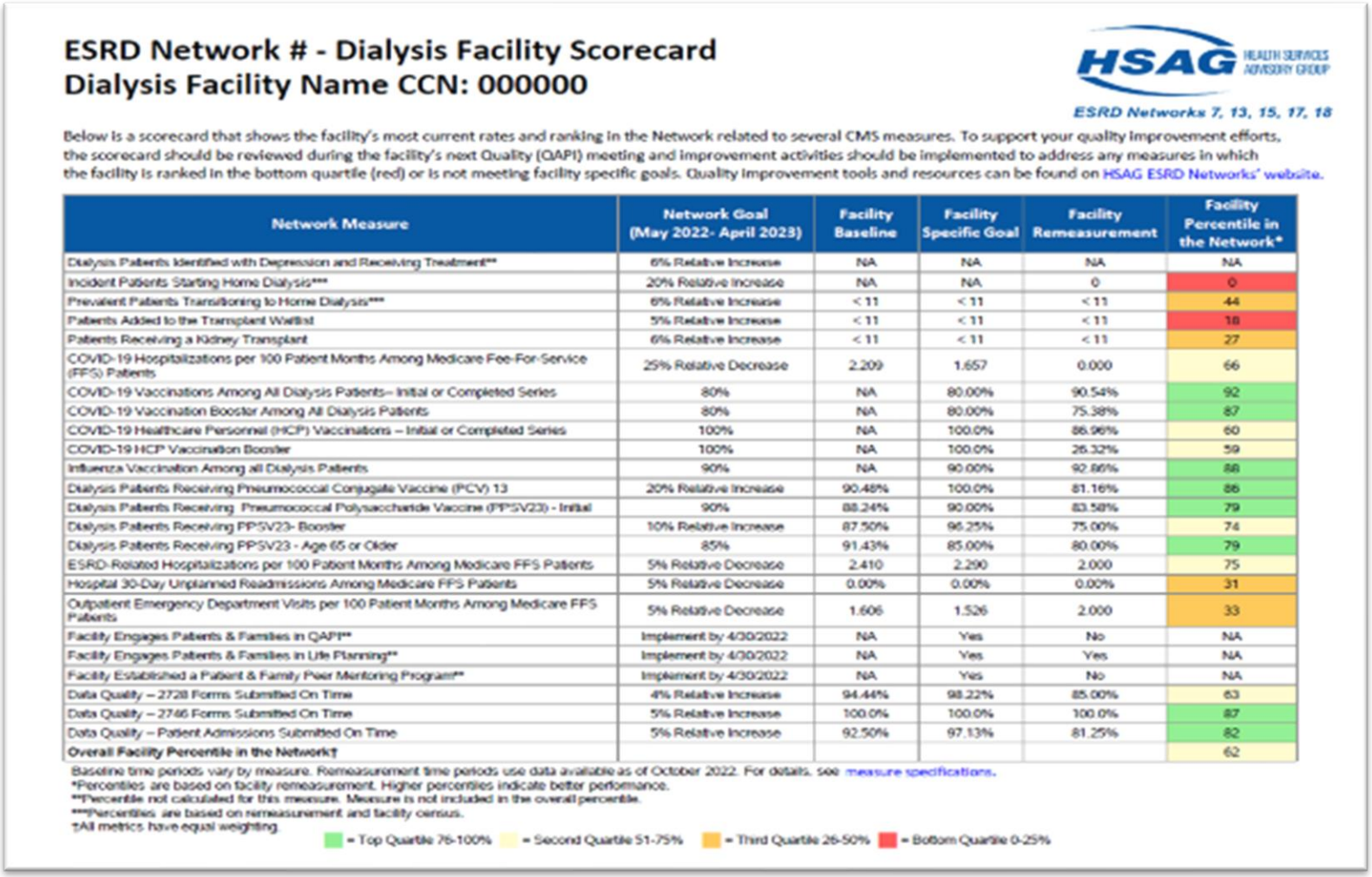


Reduce COVID-19 Hospitalizations Best Practices

- Maintain consistent screening and masking policies.
- Educate patients and staff ongoing about reducing exposure, vaccination and what to do if they become symptomatic.
- Encourage patients to call the facility if they are symptomatic or have been exposed.
- Cohort patients on the last shift, in another area of the facility, or at another facility.
- Discuss outpatient treatment options for symptom management with the patient and their physician.

Facility Level Quality Improvement

Facility Scorecards



ESRD Network # - Dialysis Facility Scorecard
Dialysis Facility Name CCN: 000000

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Below is a scorecard that shows the facility's most current rates and ranking in the Network related to several CMS measures. To support your quality improvement efforts, the scorecard should be reviewed during the facility's next Quality (QAPI) meeting and improvement activities should be implemented to address any measures in which the facility is ranked in the bottom quartile (red) or is not meeting facility specific goals. Quality improvement tools and resources can be found on HSAG ESRD Networks' website.

Network Measure	Network Goal (May 2022- April 2023)	Facility Baseline	Facility Specific Goal	Facility Remeasurement	Facility Percentile in the Network*
Dialysis Patients Identified with Depression and Receiving Treatment**	6% Relative Increase	NA	NA	NA	NA
Incident Patients Starting Home Dialysis***	20% Relative Increase	NA	NA	0	0
Prevalent Patients Transitioning to Home Dialysis***	6% Relative Increase	< 11	< 11	< 11	44
Patients Added to the Transplant Waitlist	5% Relative Increase	< 11	< 11	< 11	18
Patients Receiving a Kidney Transplant	6% Relative Increase	< 11	< 11	< 11	27
COVID-19 Hospitalizations per 100 Patient Months Among Medicare Fee-For-Service (FFS) Patients	25% Relative Decrease	2.209	1.657	0.000	66
COVID-19 Vaccinations Among All Dialysis Patients– Initial or Completed Series	80%	NA	80.00%	90.54%	92
COVID-19 Vaccination Booster Among All Dialysis Patients	80%	NA	80.00%	75.38%	87
COVID-19 Healthcare Personnel (HCP) Vaccinations – Initial or Completed Series	100%	NA	100.0%	86.96%	60
COVID-19 HCP Vaccination Booster	100%	NA	100.0%	26.32%	59
Influenza Vaccination Among all Dialysis Patients	90%	NA	90.00%	92.86%	88
Dialysis Patients Receiving Pneumococcal Conjugate Vaccine (PCV) 13	20% Relative Increase	90.48%	100.0%	81.16%	86
Dialysis Patients Receiving Pneumococcal Polysaccharide Vaccine (PPSV23) - Initial	90%	88.24%	90.00%	83.58%	79
Dialysis Patients Receiving PPSV23- Booster	10% Relative Increase	87.50%	96.25%	75.00%	74
Dialysis Patients Receiving PPSV23 - Age 65 or Older	85%	91.43%	85.00%	80.00%	79
ESRD-Related Hospitalizations per 100 Patient Months Among Medicare FFS Patients	5% Relative Decrease	2.410	2.290	2.000	75
Hospital 30-Day Unplanned Readmissions Among Medicare FFS Patients	5% Relative Decrease	0.00%	0.00%	0.00%	31
Outpatient Emergency Department Visits per 100 Patient Months Among Medicare FFS Patients	5% Relative Decrease	1.606	1.526	2.000	33
Facility Engages Patients & Families in QAPI**	Implement by 4/30/2022	NA	Yes	No	NA
Facility Engages Patients & Families in Life Planning**	Implement by 4/30/2022	NA	Yes	Yes	NA
Facility Established a Patient & Family Peer Mentoring Program**	Implement by 4/30/2022	NA	Yes	No	NA
Data Quality – 2728 Forms Submitted On Time	4% Relative Increase	94.44%	98.22%	85.00%	63
Data Quality – 2746 Forms Submitted On Time	5% Relative Increase	100.0%	100.0%	100.0%	87
Data Quality – Patient Admissions Submitted On Time	5% Relative Increase	92.50%	97.13%	81.25%	82
Overall Facility Percentile in the Network†					62

Baseline time periods vary by measure. Remeasurement time periods use data available as of October 2022. For details, see measure specifications.
*Percentiles are based on facility remeasurement. Higher percentiles indicate better performance.
**Percentile not calculated for this measure. Measure is not included in the overall percentile.
***Percentiles are based on remeasurement and facility census.
†All metrics have equal weighting.

= Top Quartile 76-100% = Second Quartile 51-75% = Third Quartile 26-50% = Bottom Quartile 0-25%

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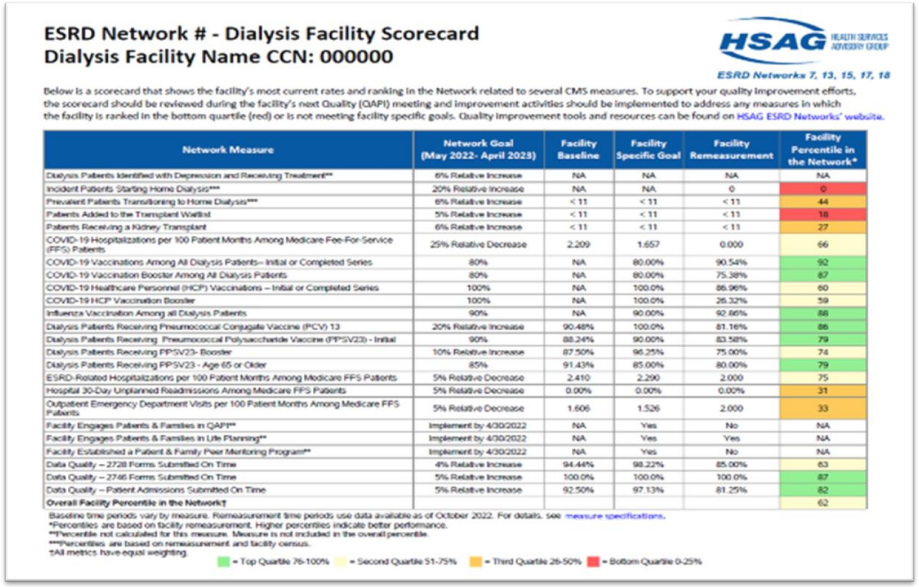
Using the Scorecard as a Tool for Facility Level Improvement

- Distributed to the facility administrator/manager email on record with the Network in January 2023.
- Shows the facility's current rates and percentile of performance within the Network related to several CMS/Network measures.
- Provides a picture of where the facility is performing related to CMS expectations and to prompt improvements.
- Support materials are available on the Network website.

Identify Areas for Improvement

- Identify metrics that do not meet the established goal or is red in the last column (bottom quartile for facility percentile in the Network)



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Dialysis Patients Receiving PPSV23- Booster	10% Relative Increase	87.50%	96.25%	75.00%	74
Dialysis Patients Receiving PPSV23 - Age 65 or Older	85%	91.43%	85.00%	80.00%	79
ESRD-Related Hospitalizations per 100 Patient Months Among Medicare FFS Patients	5% Relative Decrease	2.410	2.290	2.000	75
Hospital 30-Day Unplanned Readmissions Among Medicare FFS Patients	5% Relative Decrease	0.00%	0.00%	0.00%	31
Outpatient Emergency Department Visits per 100 Patient Months Among Medicare FFS Patients	5% Relative Decrease	1.606	1.526	2.000	33
Facility Engages Patients & Families in QAPI**	Implement by 4/30/2022	NA	Yes	No	NA
Facility Engages Patients & Families in Life Planning**	Implement by 4/30/2022	NA	Yes	Yes	NA
Facility Established a Patient & Family Peer Mentoring Program**	Implement by 4/30/2022	NA	Yes	No	NA
Data Quality – 2728 Forms Submitted On Time	4% Relative Increase	94.44%	98.22%	85.00%	63
Data Quality – 2746 Forms Submitted On Time	5% Relative Increase	100.0%	100.0%	100.0%	87
Data Quality – Patient Admissions Submitted On Time	5% Relative Increase	92.50%	97.13%	81.25%	82
Overall Facility Percentile in the Network†					62

Baseline time periods vary by measure. Remeasurement time periods use data available as of October 2022. For details, see measure specifications.
*Percentiles are based on facility remeasurement. Higher percentiles indicate better performance.
**Percentile not calculated for this measure. Measure is not included in the overall percentile.
***Percentiles are based on remeasurement and facility census.
†All metrics have equal weighting.

= Top Quartile 76-100% = Second Quartile 51-75% = Third Quartile 26-50% = Bottom Quartile 0-25%

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Compare to Internal Metrics

- Review the Scorecard measure specifications.
- Examine QAPI measures that may be similar.
- Perform a Root Cause Analysis (RCA) based on available data and information with the Interdisciplinary Team (IDT).
- Implement an action plan and use a Plan-Do-Study-Act (PDSA) cycle to test interventions.
- Use materials on the HSAG ESRD Networks website for the action plan and PDSA cycle.

Other Reminders

- ESRD QIP Payment Year (PY) 2023 Final Performance Score Reports (PSRs) and Performance Score Certificates (PSCs) are available.
  - Remind facilities to post the PSC.
- CMS-2744 Annual ESRD Facility Survey Completion Process has begun.
  - Directions were sent to all facilities.
- Email us your contact updates!
- Make sure you're on our newsletter email list.

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Thank you!

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