

# 2015 Annual Report



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# Report Highlights

CMS goals for the ESRD Network Program were successfully implemented in 2015, due largely to the sustained efforts of patients and providers working together with Network 8 in pursuit of a common goal: healthier patients enjoying an improved experience of safe and effective care. This report captures a selection of successful activities undertaken in the areas of clinical quality improvement, patient satisfaction, and information management.

Notable strides were made in a project to increase the total percentage of patients receiving vaccinations for pneumonia (PPV) and hepatitis B (HBV) and in reducing the disparity in vaccination rates between adult black and white patients dialyzing in-center. The target group of 12 facilities with the lowest vaccination rates and widest racial disparity achieved an overall 32 percentage point increase in the HBV vaccination rate, a 16 percentage point increase in the PPV vaccination rate, and a 13 percentage point reduction in the identified racial disparity, moving from a 17 percentage point difference between African American and white patients at baseline to a four percentage point difference by project end.

**Figure 1. Vaccination Project Results from April – September, 2015**

	Percent of patients vaccinated for HBV or PPV, July 1-December 31, 2014	Percent of patients vaccinated for HBV or PPV, April 1-September 30, 2015
African American	42%	70%
White	59%	74%
Disparity	17 percentage points	4 percentage points

**Source: CMS Dashboard Input Form, September 2015**

Another project included a much larger group of facilities and used structured CDC audit tools designed to help reduce dangerous bloodstream infections (BSIs). ESRD patients have experienced an increasing rate of BSIs in recent years, along with associated increases in morbidity and mortality. After a 2014 CDC quality improvement study was able to associate process audits, along with other interventions, with reduced BSI rates, the ESRD Networks were asked to introduce these advances to facilities in a Quality Improvement Activity (QIA). Facilities quickly adopted the process, and over 90% of facilities met the audit requirements within the first four months of the project. Three months after the November conclusion of the activity, a majority of facilities were voluntarily using the tools to sustain compliance with correct technique. The project group experienced a 24% reduction in BSIs in 2015 in comparison to their 2014 pooled mean rate.

These projects are presented in greater detail in the following pages. We are grateful for the contributions of patient and professional volunteers who contributed to the work represented in this report, to the countless facility staff who worked with us to deliver these activities, and to the guidance and support from CMS on whose behalf this work was performed.

# Introduction

## **CMS' End Stage Renal Disease Network Organization Program**

The End Stage Renal Disease Network Organization Program (ESRD Network Program) is a national quality improvement program funded by the Centers for Medicare & Medicaid Services (CMS). CMS is a federal agency, part of the U.S. Department of Health and Human Services.

CMS defines end stage renal disease (ESRD) as permanent kidney failure in an individual who requires dialysis or kidney transplantation to sustain life.

Under contract with CMS, 18 ESRD Network Organizations, or ESRD Networks, carry out a range of activities to improve the quality of care for individuals with ESRD. The 18 ESRD Networks serve the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, and the Northern Mariana Islands.

## **Medicare Coverage for Individuals with ESRD**

Medicare coverage was extended to most ESRD patients in the U.S. under the Social Security Act Amendments of 1972 (Public Law 92-603). Individuals with irreversible kidney failure are eligible for Medicare if they need regular dialysis or have had a kidney transplant and they meet (or their spouse or parent meets) certain work history requirements under the Social Security program, the railroad retirement system, or federal employment.

## **History of CMS' ESRD Network Organization Program**

Following passage of the 1972 Amendments to the Social Security Act, in response to the need for effective coordination of ESRD care, hospitals and other health care facilities were organized into networks to enhance the delivery of services to people with ESRD.

In 1978, Public Law 95-292 modified the Social Security Act to allow for the coordination of dialysis and transplant services by linking dialysis facilities, transplant centers, hospitals, patients, physicians, nurses, social workers, and dietitians into Network Coordinating Councils, one for each of 32 administrative areas.

In 1988, CMS consolidated the 32 jurisdictions into 18 geographic areas and awarded contracts to 18 ESRD Network Organizations, now commonly known as ESRD Networks. The ESRD Networks, under the terms of their contracts with CMS, are responsible for: supporting use of the most appropriate treatment modalities to maximize quality of care and quality of life; encouraging treatment providers to support patients' vocational rehabilitation and employment; collecting, validating, and analyzing patient registry data; identifying providers that do not contribute to the achievement of Network goals; and conducting onsite reviews of ESRD providers as necessary.

Network 8, Incorporated, formed in 1988, serves the states of Alabama, Mississippi, and Tennessee. The Network 8 administrative office is located in Ridgeland, Mississippi, where 10 staff members share responsibilities for delivering services specified in the Network's contract

with CMS. They receive administrative guidance from the Board of Directors, program oversight from the Medical Review Board, and program development advice and consultation from patient and provider committees. In 2012, the company merged with Alliant Quality, a division of Alliant Health Solutions in Atlanta, Georgia, in order to gain administrative efficiencies as a member of a growing family of quality-focused companies. In January 2015, ESRD Network 6, Southeastern Kidney Council, Inc., and ESRD Network 14 also merged with Alliant Quality and joined with Network 8 to form the Alliant Quality Kidney Collaborative.

Alabama and Mississippi share more geographic, climate, population, and cultural similarities with each other than with their neighbor to the north, Tennessee, which is smaller in territory and has more topographic and demographic diversity, and ties Missouri for sharing boundaries with the most states (eight).

Alabama lies at the southern end of the Appalachian Mountains and extends southward from the Tennessee border to the Gulf of Mexico and the Florida panhandle. The state covers 52,419 square miles and borders Mississippi to the west, Georgia to the east and Tennessee to the north. Urban areas include Birmingham (the largest city), Montgomery (the capital), Mobile and Huntsville.

Mississippi borders Tennessee to the north, the Gulf of Mexico to the south, and Alabama to the east, and shares its western border with Arkansas and Louisiana. The state covers 48,430 square miles. The largest city and capital, Jackson, is located in the central part of the state. Other large towns include Gulfport and Biloxi on the Gulf Coast, Hattiesburg to the south of Jackson, Greenville in the northwest and Tupelo in the northeast.

Tennessee's geography and topography differ substantially from those of the other two states, with a maximum north-south distance of only 115 miles and an east-west span of some 491 miles. It covers 42,143 square miles, and its regions are so different from each other that three distinct divisions are canonized in state law: West Tennessee, Middle Tennessee and East Tennessee. Population centers include Memphis in West Tennessee, Nashville (state capital) in Middle Tennessee and Knoxville and Chattanooga in mountainous East Tennessee.

Mississippi, the most rural of the three states, has the fewest residents but the highest percentage of African Americans and the highest percentage of people living in poverty. Alabama, the second most rural and the second highest in population, has the second highest percentage of African Americans and the third highest percentage of people living in poverty. Tennessee is the most populous of the three states, has the lowest rural and African American populations, and the second highest percentage of people living in poverty. African Americans are disproportionately affected by ESRD, by poverty, and by reduced access to primary care resources in the many rural locations of the region.

**Table A. Dialysis Facilities and Transplant Centers in the Network’s Service Area, as of December 31, 2015**

Category	Number
Number of Dialysis Facilities in the Network’s Service Area	420
Number of Transplant Centers in the Network’s Service Area	11

Source of data: CROWNWeb.

The expansion of dialysis facilities generally has kept pace with the growing number of dialysis patients, but having a single transplant center in both Alabama and Mississippi represents a greater barrier to access in those states than in Tennessee, which has one or more hospitals offering transplantation in each of its three regions.

**Table B. Number of Medicare-Certified Dialysis Facilities in the Network’s Service Area and Number and Percent of Dialysis Facilities Offering Dialysis Shifts Starting after 5 PM, as of December 31, 2015**

Category	Number	Percent
Number of Dialysis Facilities in the Network’s Service Area	420	
Dialysis Facilities in the Network’s Service Area Offering Dialysis Shifts Starting after 5 PM	26	6.2%

Source of data: CROWNWeb.

The small number of facilities offering services after 5 PM is closely associated with the relatively low number of employed patients in Network 8’s service area (see Table 8).

## Network Goals

CMS establishes priorities for the ESRD Network contractors annually in the Statement of Work section of each Network’s contract with the agency. These priorities support CMS and Department of Health and Human Services (HHS) national quality improvement goals and priorities.

In 2015, the ESRD Network contractors were tasked with meeting the following goals:

- Improving care for ESRD patients in the Network’s service area by:
  - Promoting patient- and family-centered care
  - Responding to grievances about ESRD-related services filed by, or on behalf of, ESRD patients
  - Supporting improvement in patients’ experience of care
  - Working with dialysis facilities to ensure that all dialysis patients have access to appropriate care

- Promoting best practices in vascular access management; and
- Helping dialysis facilities reduce the incidence of healthcare-associated infections.
- Improving the health of the ESRD patient population in the Network's service area through activities designed to reduce disparities in ESRD care; and
- Reducing the costs of ESRD care in the Network's service area by supporting performance improvement at the dialysis facility level and supporting facilities' submission of data to CMS-designated data collection systems.

## Profile of Patients in the Network’s Service Area

The ESRD Network Program collects data on incident (new) ESRD patients, prevalent (currently 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.

**Table C. Clinical Characteristics of the ESRD Population in the Network’s Service Area, Calendar Year 2015**

<b>Category</b>	<b>Number</b>	<b>Percent</b>
<b>Incident (New) ESRD Patients</b>		
Number of Incident ESRD Patients, Calendar Year 2015	6569	
<b>Prevalent Dialysis Patients</b>		
Number of Prevalent Dialysis Patients as of December 31, 2015	26998	
<b>Treatment Modality of Prevalent Dialysis Patients as of December 31, 2015</b>		
In-Center Hemodialysis or Peritoneal Dialysis	23662	88%
In-Home Hemodialysis or Peritoneal Dialysis	3359	12%
Total	27021	100%
<b>Vascular Access Type at Latest Treatment among Prevalent In-Center and In-Home Hemodialysis Patients as of December 31, 2015</b>		
Arteriovenous Fistula in Use	14456	61%
Arteriovenous Graft in Use	4873	21%
Catheter in Use for 90 Days or Longer	2342	10%
Other	1958	8%
Total	23,629	100%
<b>Renal Transplants</b>		
Number of Renal Transplant Recipients,* Calendar Year 2015		
Total	805	100%

Source of data: CROWNWeb.

\*Count of unduplicated individuals receiving renal transplantation during the calendar year.



# Improving Care for ESRD Patients

Network 8 works closely with ESRD patients, patients' family members and friends, nephrologists, dialysis facilities and other healthcare organizations, ESRD advocacy organizations, and other ESRD stakeholders to improve the care for ESRD patients in Mississippi, Alabama and Tennessee.

Under its contract with CMS, the Network is responsible for:

- Identifying opportunities for quality improvement and developing interventions to improve care for ESRD patients in Mississippi, Alabama and Tennessee
- Identifying opportunities for improvement at the facility level and providing technical assistance to facilities as needed
- Promoting the use of best practices in clinical care for ESRD patients
- Encouraging use of all modalities of care, including home modalities and transplantation, as appropriate, to promote patient independence and improve clinical outcomes
- Promoting the coordination of care across treatment settings; and
- Ensuring accurate and timely data collection, analysis, and reporting by facilities in accordance with national standards.

## Population Health Innovation Project

Following successful interventions for increasing transplant referrals in the Network 8 service area in 2013 and 2014, the topic "Increase Hepatitis B (HBV) and Pneumococcal Vaccination (PPV) Rates" was selected for the Population Health Innovation Pilot Project for 2015. ESRD Network 14, corporate partner of Network 8, had conducted this project with exceptional results in Texas in 2014 by employing a Lean Six Sigma improvement process, and those results and strategies were made available corporate-wide in January 2015 as topics for quality projects were being selected.

Because the vaccination project was limited in scope to a small group of in-center hemodialysis facilities, and because a clear racial disparity in outcomes was evident in CMS-supplied data, the selection offered an ideal opportunity to pilot the use of the proven DMAIC (define, measure, analyze, improve, control) process in a manageable cohort while mastering the elements of the process.

Project goals were two-fold: achieve a five percentage point increase in vaccination rates for each of the two vaccine types by September 2015 along with a one percentage point reduction in the African American/white racial disparity. Facilities chosen included six in Alabama, four in

Mississippi and two in Tennessee, based on a disparity of at least four percentage points between black patients and white patients. Setting the disparity floor at four percentage points assured that facilities with the greatest racial disparities would fall into the targeted group.

Facility selection began with a baseline disparity calculation for both vaccines performed on data supplied by the National Coordinating Center, a CMS contractor. Following these calculations, filters were applied, assuring a minimum of 20 African American patients and 20 white patients in each facility, which eliminated small facilities with populations less than 40. The next step in the selection process was to sort the data based on highest PPV disparity, leaving 20 facilities for consideration. Included in this list of 20 were two home programs, each with only three hemodialysis patients among their larger peritoneal dialysis populations. Those two units were excluded, leaving 18 units.

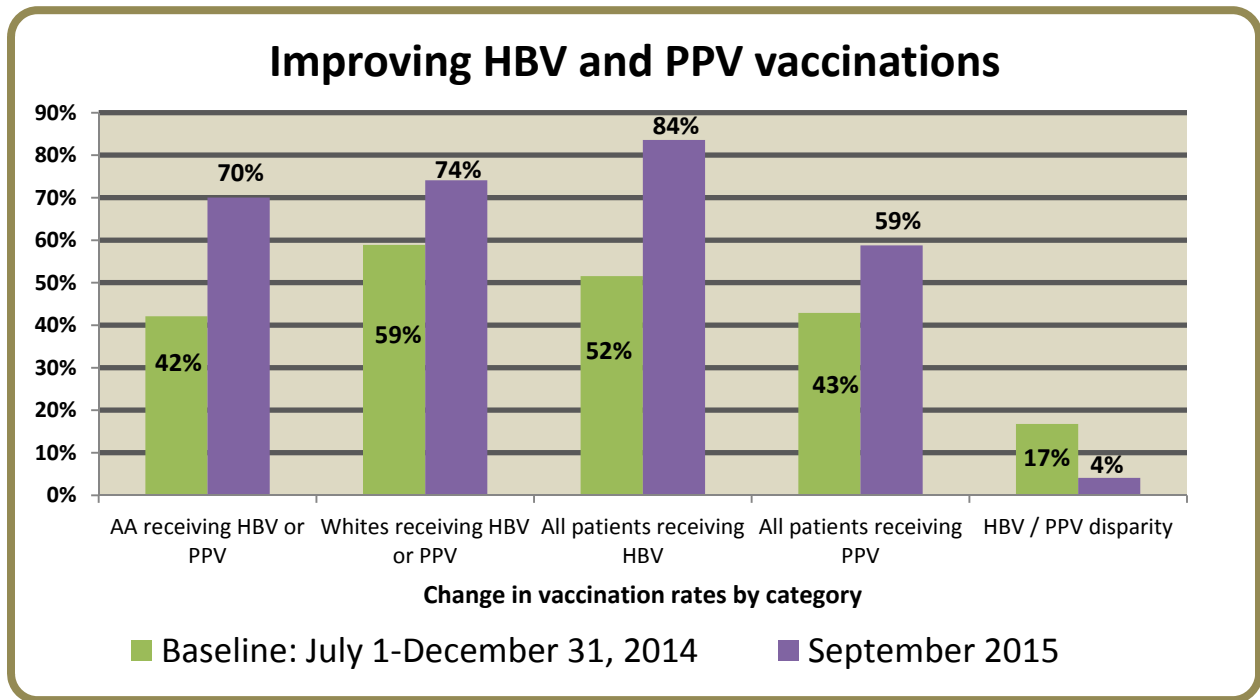
Each of the 18 facilities was then cross-checked against the participant list for the Healthcare-Associated Infections QIA (see below), and four units already chosen for the HAI project were intentionally de-selected to prevent project overload at the facility level. Two additional units were de-selected due to recent changes in nurse managers and the need for significant local-level reorganization. Of the 12 facilities left for inclusion in the project, two were deselected due to higher than average vaccination rates overall. To bring the overall project group back to our desired 12-facility minimum, the final two units selected were those with next highest racial disparity in overall vaccination rates.

Individual phone calls were made to facility staff to gain a deeper understanding of the causes of racial disparities. Patient preference explained some of the differences. A more common finding was lack of staff awareness that a disparity existed. A case in point was a facility with a predominately African American patient population and a largely African American staff, including the nurse manager. After they were made aware of the disparity, the staff worked diligently with the Network to reach out to patients to inform them of the risks of not being vaccinated. Other reported root causes of low vaccination rates for both African American and white patients included fear of needles and fear of contracting illness from the vaccine.

In cooperation with facility staff, Network 8 prepared letters tailored to the needs of individual patients. The letters informed patients of the specific vaccinations that were needed and the reason they were important, using appropriate literacy level handouts. Letters were mailed directly to patients; all returns were resent to new patient addresses or addressed to patients at facility address. Additionally, staff education materials were sent to each intervention unit to better educate staff on the importance of vaccinations and to ensure that staff was informed and able to answer patient questions about each vaccine type.

As noted in Figure 2, project goals for improvements in each vaccination type were met with an overall 32 percentage point improvement in HBV vaccination rates, a 16 percentage point improvement in PPV vaccination rates and a 13 percentage point reduction in racial disparity, moving from a 17 percentage point difference between groups at baseline to a four percentage point difference by project end.

**Figure 2. Improving HBV and PPV vaccinations project outcomes**



	AA patients receiving HBV or PPV	White patients receiving HBV or PPV	All patients receiving HBV	All patients receiving PPV	HBV / PPB disparity
Baseline	365 / 867 = 42.0%	225 / 382 = 58.9%	644 / 1249 = 51.6%	536 / 1249 = 41.9%	42.1% AA / 58.9% white = 16.8 percentage points
September 2015	582 / 831 = 70.0%	248 / 334 = 74.3%	974 / 1165 = 83.6%	685 / 1165 = 58.8%	70.0% AA / 74.1% white = 4.1 percentage points

Source of data: CROWNWeb. (AA patients: African-American patients)

### Healthcare-Associated Infections QIA

Network 8 developed a Quality Improvement Activity (QIA) that included 20% of Network-area facilities. The QIA was implemented in April 2015, and 86 facilities were selected to participate in the project. Selection criteria were based on facilities with the highest bloodstream infection (BSI) rates, as reported to the National Healthcare Safety Network (NHSN) from January 1, 2014, through December 31, 2014. The QIA required facilities to conduct the following minimum numbers of audits, using the Centers for Disease Control and Prevention (CDC) audit tools: 30 hand hygiene observations, 10 catheter connection/disconnection observations, and 10 fistula/graft cannulation observations. The QIA metrics were as follows:

**Table D: HAI QIA Metrics**

<b>Project Measurement</b>	<b>Hand Hygiene</b>	<b>Catheter Connection / Disconnection</b>	<b>Fistula / Graft Cannulation</b>
Numerator	# of Successful Hand Hygiene Opportunities Observed	# of Procedures Performed Correctly	# of Procedures Performed Correctly
Denominator	Total # of Hand Hygiene Opportunities Observed During Audit	Total # of Procedures Observed During Audit	Total # of Procedures Observed During Audit

Figure 3 depicts the percentage of facilities that successfully completed the minimum number of observations from April 1, 2015, through November 30, 2015. For 5 consecutive months, more than 90% of QIA facilities successfully completed the minimum number of CDC audits.

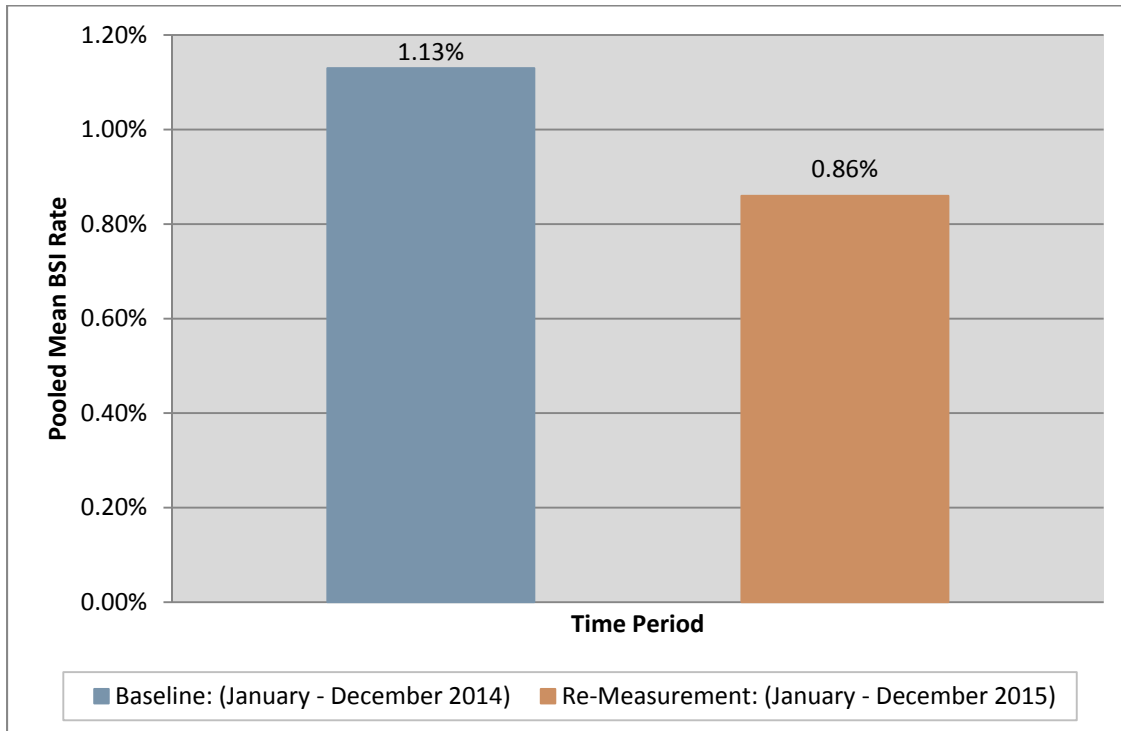
**Figure 3. Percentage of Facilities that Successfully Completed the Minimum Number of Observations**

	<b>Apr</b>	<b>May</b>	<b>Jun</b>	<b>Jul</b>	<b>Aug</b>	<b>Sep</b>	<b>Oct</b>	<b>Nov</b>
Hand Hygiene	84%	87%	90%	95%	99%	100%	100%	93%
Catheter Connection/Disconnection	84%	87%	86%	95%	98%	100%	99%	92%
Fistula/Graft Cannulation	83%	87%	85%	95%	98%	100%	100%	93%

Source of data: CMS Dashboard Input Form

Upon completion of the project, QIA facilities successfully decreased the pooled mean BSI rate by 0.27 percentage points, or 24%. (See Figure 4.) To ensure sustainability, Network 8 continued to track BSI rates and analyze the NHSN Prevention Process Measures (PPM) of QIA facilities for three months after the completion of the project. It was determined that 88% of facilities were continuing to use the CDC audits as a part of their QI process.

**Figure 4. Facility Pooled Mean BSI Rates in Project Facilities**



Source of data: NHSN

### **Facilities that Consistently Failed to Cooperate with Network Goals**

Providers in the Network region are monitored throughout the year for their participation in activities specified in the CMS Statement of Work and for their performance on a number of quality metrics. ESRD Networks may recommend that sanctions or alternative sanctions be imposed on facilities that do not cooperate in meeting Network goals or CMS standards of care. During 2015 there were no providers that consistently failed to cooperate with Network goals.

### **Recommendations to CMS for Additional Services or Facilities**

There was a net increase of 15 facilities in 2015, representing 18 new openings and three closures. Because the increase in facilities appears to be on track with the growth and the shifting modalities of patients, the Network has not identified a specific need for additional facilities in the service area.

## Grievances and Access to Care

Network 8 works with individual facilities to identify and address difficulties in placing or maintaining patients in treatment. These access-to-care cases may come to the Network’s attention in the form of a grievance, or may be initiated by facility staff.

Access-to-care cases include involuntary discharges, involuntary transfers, and failures to place. An involuntary discharge is a discharge initiated by the treating dialysis facility without the patient’s agreement. An involuntary transfer occurs when the transferring facility temporarily or permanently closes due to a merger, due to an emergency or disaster situation, or due to other circumstances, and the patient is dissatisfied with the transfer to another facility. A failure to place is defined as a situation in which no outpatient dialysis facility can be located that will accept an ESRD patient for routine dialysis treatment.

In 2015, the Network responded to 65 grievances (Table D.). Of these, 8 (13%) involved issues related to access to care. Of the 65 patient grievances, a majority were addressed using Immediate Advocacy (n=43). Immediate advocacy is a dispute resolution process in which the Network is able to quickly resolve a grievance by making direct contact with the involved provider and/or practitioner(s).

**Table E. Grievance Data for Calendar Year 2015**

Category	Number
Number of Grievance Cases Opened in Calendar Year 2015	65
Number of Grievance Cases Involving Access to Care	8
Number of Grievance Cases Involving Involuntary Transfer	0
Number of Grievance Cases Involving Involuntary Discharge	0
Number of Grievance Cases Involving Failure to Place	3
Number of Non-Grievance Cases Involving Access to Care	228
Number of Non-Grievance Access to Care Cases Involving Involuntary Transfer	0
Number of Non-Grievance Access to Care Cases Involving Involuntary Discharge	27
Number of Non-Grievance Access to Care Cases Involving Failure to Place	13
Number of Grievance Cases Closed by the Network in Calendar Year 2015	57
Number of Non-Grievance Access to Care Cases Closed by the Network in Calendar Year 2015	219

Source of data: Patient Contact Utility.

Networks use a Patient Contact Utility (PCU) to log grievance contacts, which are classified according to one of four categories (Figure 5). Network 8 received six patient-specific quality of care review grievances. A patient-specific quality of care review is conducted by the Network in response to a grievance alleging that (a) an individual patient’s rights were violated and/or that (b) an ESRD service received from a Medicare-certified provider did not meet professionally recognized standards of clinical care and/or professional conduct and the failure to meet recognized standards resulted or potentially resulted in an adverse clinical outcome for the patient.

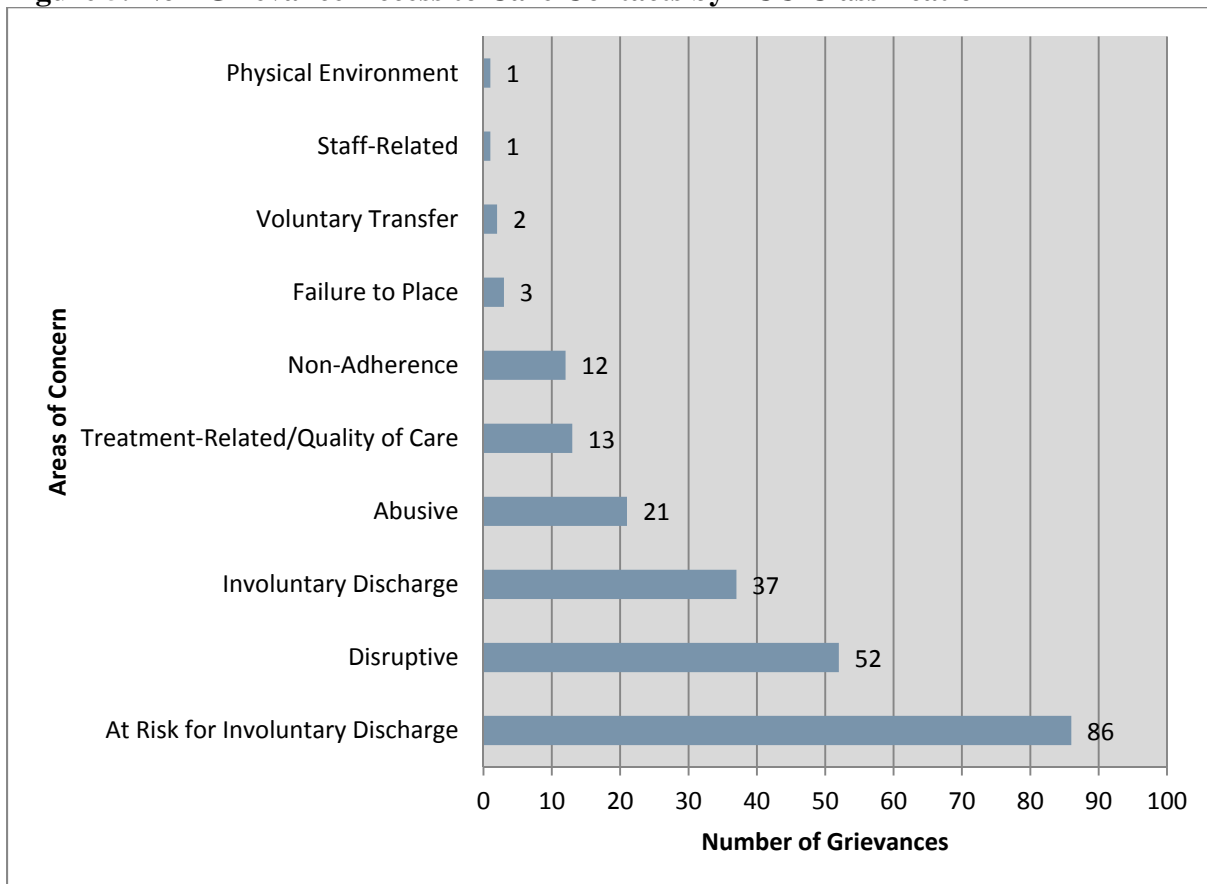
<b>Table F. Grievances Processed in 2015 by Patient Contact Utility Classification</b>	<b>Patient-Specific Quality of Care</b>	<b>General Quality of Care</b>	<b>Immediate Advocacy</b>	<b>Access to Care</b>
Abusive	0	0	1	0
Disruptive	0	0	2	4
Physical Environment	1	0	4	0
Staff-Related	0	1	16	0
Treatment- Related	5	7	20	4

Source of data: Patient Contact Utility

Eight grievances were classified as general quality of care grievances. A general quality of care review is conducted by the Network in response to a concern that (a) the rights of two or more ESRD patients may have been violated and/or (b) that ESRD services received from a Medicare-certified provider did not meet professionally recognized standards of clinical care and/or professional conduct and that the failure to meet recognized standards potentially resulted in an adverse clinical outcome for more than one patient.

As reflected in Figure 5, there were 228 non-grievance access-to-care calls. This category is utilized when a facility staff, physician, hospital staff, or other professional contact the Network for assistance with addressing patient issues. The primary area of concern for access-to-care calls were categorized as follows: 86 at risk for involuntary discharge, 37 involuntary discharge calls, 52 calls related to disruptive patient behaviors, 21 calls related to abusive patient behaviors, 13 treatment related issues, and 12 nonadherence calls. Smaller categories included failure to place, voluntary transfers, staff related concerns, and physical environment.

**Figure 5. Non-Grievance Access to Care Contacts by PCU Classification**



Source of data: Patient Contact Utility

When involuntary discharge and disruptive and abusive patient behaviors are the issue, Network 8 thoroughly reviews the involuntary discharge process as outlined by CMS to ensure all steps have been followed. The Network staff is instrumental in providing interventions to assist the facility staff with addressing disruptive and abusive behaviors in an attempt to avert an involuntary discharge. In 2015, Network 8 successfully averted 79 involuntary discharges.

When non-adherence is the issue, Network 8 advocates for the patient's right to self-determination and discusses methods of educating the patients to ensure they understand the consequences of this behavior. The facility is educated on methods to manage the behavior such as exploring home modalities, involving the patient's support system, evaluating for depression and other psychosocial barriers to the patient attending treatment, and reassigning the patient to a later shift and delaying machine set-up until the patient arrives.



## Involuntary Discharges

When a patient is involuntarily discharged from a facility, Network 8 ensures that the facility provides the necessary information and documentation to Network 8 staff. All facility administrators, nurse managers and social workers were provided the involuntary discharge packet from the Network. Network 8 requires documentation for all involuntary discharges, and the packet serves as a guide for facilities in providing the appropriate and complete information.

Network 8 has a tracking system for the involuntary discharges that have been averted due to its intervention. Facilities are required to notify Network 8 prior to providing the patient with a 30-day notice, and efforts are made then to avert the discharge during the initial phone call with facility staff. The PSD discusses alternate interventions and reviews the Medicare regulations with the facility and ensures that all efforts of working with the patient have been attempted and the discharge is the last resort. Of the 106 potential involuntary discharges reported to Network 8 in 2015, 79 (75%) were averted.

Network 8 assists facility staff in averting involuntary discharges by implementing early intervention whenever possible. Patients who are involuntarily discharged often experience difficulty locating a new facility and are forced to receive emergent dialysis at a local hospital. Due to this serious barrier to treatment, Network staff members encourage early reporting of behavioral issues in order to focus on minimizing inappropriate patient behaviors before they escalate to a state of crisis.

When involuntary discharges occurred in 2015, Network 8 staff reviewed the information to look for patterns by states, race, gender, dialysis corporation, and whether the patient was placed in another facility as shown in Figures 6-8. Immediately after an involuntary discharge, 14 patients (52%) were denied treatment at area outpatient dialysis facilities and were receiving emergency dialysis at a local hospital. Network staff conducted a follow-up of those 14 patients and six were placed in an outpatient facility within six months of the involuntary discharge and the remaining eight patients continued to receive dialysis at a local hospital.

**Table 6. Involuntary Discharges by State**

Involuntary Discharges by State		
	Number	Percent
Alabama	6	22%
Mississippi	4	15%
Tennessee	17	63%
Total	27	100%

**Table 7. Primary Cause of Involuntary Discharge**

Primary Cause of Involuntary Discharge		
	Number	Percent
Disruptive/Abusive Behavior (30-day notice)	0	0%
Immediate Discharge Due to Severe Threat	16	59%
Lack of Payment	2	7%
Physician Discharge from Services	8	30%
Unable to Meet Medical Needs	1	4%
Total	27	100%

**Table 8. Patient Placement after Involuntary Discharge**

Patient Placement After Involuntary Discharge		
	Number	Percent
New Facility	13	48%
Emergency Room	14	52%
Total	27	100%

Source of data for Figures 6, 7, 8: Patient Contact Utility

### Grievance QIA

The Grievance Quality Improvement Activity (QIA) identified one grievance trend to address by implementing activities with five facilities with grievances in the trend area. Network 8 conducted a focused audit of grievances for January 2014 through March 31, 2015. The Network reviewed grievances by the primary area of concern. The grievance analysis demonstrated that staff related grievances represented the largest percentage of grievances (45.7%). Staff related grievances were further analyzed to determine specific categories of grievances related to the staff. There were 43 staff related grievances, and 25 of those involved concerns about professionalism. The findings from the grievance analysis were presented to the Medical Review Board (MRB) and under their direction the QIA addressed improving professionalism.

In the past, facilities reported that Network projects were time-consuming for staff; a promising approach was the use of monthly recorded educational modules. All of the staff education for this QIA was provided via the educational modules. This allowed the facility champion to show the modules during monthly staff meetings or allow staff to view them individually. All clinic managers were receptive to this avenue of providing education and thought it would minimize time and facility resources. The topics for the monthly recorded educational modules included:

- How to utilize your Network Training Module
- Professionalism Training Module
- Improving Communication in the Dialysis Setting Training Module
- Addressing Patient Concerns Training Module.

## Process Measure

CMS required the Network to demonstrate improvement from the baseline period (January 2014–March 2015) to the re-measurement period (May 1–September 30, 2015) in the number of topic-area grievances per 100 prevalent patients for the QIA facilities as a group.

One facility indirectly received a topic area grievance. The grievance was an anonymous grievance received through the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS), an instrument designed to elicit consumer experience of care. The complaint regarded multiple concerns, including the professionalism of an employee. Interventions were provided to the facility to address the concerns and required successful completion of the Grievance QIA activities. Network 8 developed a tool to measure facility staff knowledge before and after the interventions. The survey contained two questions from each of the four educational modules. The eight questions were multiple choice, and each question had one correct response. Each question was scored as correct or incorrect and each staff member had a total score of one through eight based on the number of correct responses.

Staff was provided with a pretest to obtain a baseline measure of professionalism knowledge and behaviors. Network 8 received 58 staff pretest responses, with an average of five of eight questions answered correctly. A majority of the incorrect answers were in the topic area of professionalism and addressing patient concerns. At the conclusion of interventions, the facility staff completed a posttest. All facilities demonstrated an improvement in total scores.

To ensure sustainability of the outcomes, Network 8 discussed individually with each facility methods of incorporating the educational modules into their routine staff education initiatives. Sustainability methods included annual staff education to view the modules and staff reeducation if there is a subsequent grievance.

Facility staff was provided an opportunity to provide feedback on their experiences. Some of the comments:

- Doing these tests today and we obviously have room for improvement – some of the answers have surprised me which is what I suppose we are trying to remedy.
- A lot of good information in a short time. Thanks!
- I found the modules to be very informative and I certainly benefited as well from participating in this training.

## **Grievance Cases Referred to State Survey Agencies**

Grievances that involve the ESRD Conditions for Coverage are coordinated with or referred to the State Survey Agency. Network 8 referred three grievances to State Agencies in 2015. The first was a patient-specific quality of care grievance alleging that the needles used at the dialysis unit led to pain and damage to the patient's vascular access. The second referral was a general quality of care grievance forwarded from CMS as a result of the ICH CAHPS survey. The grievant expressed concerns that patients were becoming hypotensive during treatments and that the cold temperature in the facility was causing patients to develop pneumonia. The third, involved the physical environment of the clinic, including concerns about an insect infestation and improper cleaning of the equipment. Network 8 worked closely with the State Survey Agencies to resolve these grievances. The cases were investigated by the State Survey Agency, and at the conclusion of the investigations there was no identified need for the Network to implement quality improvement activities based on the findings.

## **Emergency Preparedness and Response**

In February 2015, Winter Storm Octavia blanketed areas of Tennessee and Alabama, and extreme conditions led to state of emergency declarations in all three states in the region. In Tennessee, authorities said virtually every road had become a solid sheet of ice, and power outages were common in all three states. The National Weather Service reported that Octavia was the most significant ice storm Nashville had seen in 20 years. Twenty-one dialysis facilities felt the impact of the storm, and Network staff stayed in contact with affected facilities throughout the duration of the event. Due to facility implementation of emergency planning at the local level, most of the impacted facilities dialyzed patients on Sunday before the storm and resumed normal operations within three days. On March 5–6, 2015, areas of Tennessee and Alabama again were hit with severe winter weather, which affected 10 Network facilities. The Tennessee Emergency Management Agency (EMA) reported that Memphis area schools and businesses were closed after four and a half inches of snow and sleet accumulated. According to the EMA, major interstate arteries were impassable and citizens were unable to get out of their driveways. In Alabama the temperature dropped 49 degrees in 18 hours, and a sheet of glaze and ice on roads made travel extremely dangerous. Schools and city offices were closed in the northern part of the state, where an inch of sleet was recorded. As with Octavia, schedule adjustments were made ahead of the storm to accommodate patients needing treatment. Network staff confirmed that there were two facility closures, and those facilities made provisions for patients who were unable to dialyze on those days. The Kidney Community Emergency Response (KCER) contractor, a program that serves as the leading authority on emergency preparedness and response for the kidney community, was on standby during both events, and Network 8 kept KCER and CMS informed of changing conditions.

Facility capacity to respond to emergencies is maintained through the support of their parent corporate organizations and through the ongoing support of the Network. In addition to concentrated educational outreach during September's National Preparedness Month, the Network provides all-hazard reminders each spring when flooding, tornados, and hurricanes are most prevalent. Network capacity is enhanced through ongoing collaborations with EMAs and through annual desktop exercises coordinated by the KCER contractor. The Network maintains an updated comprehensive emergency management plan and has a reciprocal relationship with a partner Network organization that can provide "stand-in" services to this region in case a catastrophic event occurs at the organization's work site.

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## **Appendix. Data Tables**

See separate file for the tables listed above.