

2016 Annual Report



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# Report Highlights

ESRD Network 8 promotes equitable, safe, and patient centered healthcare for ESRD patients in Alabama, Mississippi, and Tennessee. In 2016, we actively collaborated with 457 dialysis and transplant providers to improve the quality of care and quality of life for ESRD patients. This report features activities conducted during calendar year 2016. CMS goals for the ESRD Network Program were successfully met during the year through collaborative efforts of patients, health professionals, and Network staff. This report highlights the promotion and implementation of patient- and family-centered activities in an effort to improve patient care.

One highlight is the reduction of the long-term use of central venous catheters (CVCs) by 2.0 percentage points, from 15.12% to 13.10% among a cohort of facilities participating in our catheter reduction quality improvement activity. During the project, 150 patients received a permanent vascular access, reducing their risk of infections. Numerous interventions were implemented with 156 facilities. The facilities were assigned to the Tier One group (in use catheter rates  $\geq 15\%$ ) with more intense interventions or the Tier Two group (in use catheter rates  $>10\%$  but  $<15\%$ ). A highly successful intervention was monthly coaching calls with Tier One facilities to conduct patient-specific reviews of catheter patients and barriers to catheter removal.

Also of note is the improvement in vaccination rates for 25 project facilities. Over the course of this QI activity, hepatitis B and pneumococcal pneumonia vaccination rates among eligible adult in-center patients improved by 19.31% and 31.49% respectively. To put this into perspective, 332 patients were vaccinated against hepatitis B and 468 patients were vaccinated against pneumococcal disease during the project period. Using a difference in differences test, there was a statistically significant increase in pneumonia vaccination rates among project facilities with the pneumonia vaccination rate increasing from 8% to 61% for project facilities with non-project facility rates increasing from 44% to 66%.

Network 8 engaged 10 facilities to improve communication with patients and promote the internal grievance process. All project facilities identified a facility patient representative and staff project champion to collaborate to address common patient grievances at the facility level. Monthly, Network staff reviewed and scored the project facilities' grievance logs using the Centers for Medicare & Medicaid Services (CMS) five-point scale based on the grievance severity and category. The project was measured by total grievance score (numerator) / total number of project facilities (denominator). The baseline grievance ratio for project facilities was 2.5%. The goal of the project was to decrease the average grievance score by 20%. At the conclusion of the project, the overall grievance ratio was 0.07%, exceeding the goal of 2.0%. We look forward to continued collaboration and success, with an ultimate goal of improvement in patient health outcomes and experience of care.

# 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.

ESRD Network 8, Inc., 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 implementing 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 based in Atlanta, Georgia, to gain administrative efficiencies as a member of a growing family of quality-focused companies. The ESRD Network of Texas (Network 14) later merged with Alliant Quality. The two Networks formed 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 shares boundaries with eight states.

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. 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.

Tennessee’s geography and topography differ substantially from those of the other two states. 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 has the second highest percentage of people living in poverty. African Americans are disproportionately affected by ESRD, by poverty, and by limited 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, 2016**

Category	Number
Number of Dialysis Facilities in the Network’s Service Area	445
Number of Transplant Centers in the Network’s Service Area	12

Source of data: CROWNWeb.

**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, 2016**

Category	Number	Percent
Number of Dialysis Facilities in the Network’s Service Area	439	
Dialysis Facilities in the Network’s Service Area Offering Dialysis Shifts Starting after 5 PM	25	6%

Source of data: CROWNWeb.

## 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 2016, 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 2016**

Category	Number	Percent
<b>Incident (New) ESRD Patients</b>		
Number of Incident ESRD Patients, Calendar Year 2016	6,922	
<b>Prevalent Dialysis Patients</b>		
Number of Prevalent Dialysis Patients as of December 31, 2016	27,865	
Treatment Modality of Prevalent Dialysis Patients as of December 31, 2016		
In-Center Hemodialysis or Peritoneal Dialysis	24,380	87.4%
In-Home Hemodialysis or Peritoneal Dialysis	3,490	12.5%
Total	27,870	100%
<b>Vascular Access Type at Latest Treatment among Prevalent In-Center and In-Home Hemodialysis Patients as of December 31, 2016</b>		
Arteriovenous Fistula in Use	14,999	61.39%
Arteriovenous Graft in Use	5080	20.79%
Catheter in Use for 90 Days or Longer	2310	9.45%
Other	2044	8.37%
Total	24,433	100%
<b>Renal Transplants</b>		
Number of Renal Transplant Recipients,* Calendar Year 2016	174	
Total		100%

Source of data: CROWNWeb.

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

# Improving Care for ESRD Patients

The Network 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 Alabama, Mississippi 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 Alabama, Mississippi 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

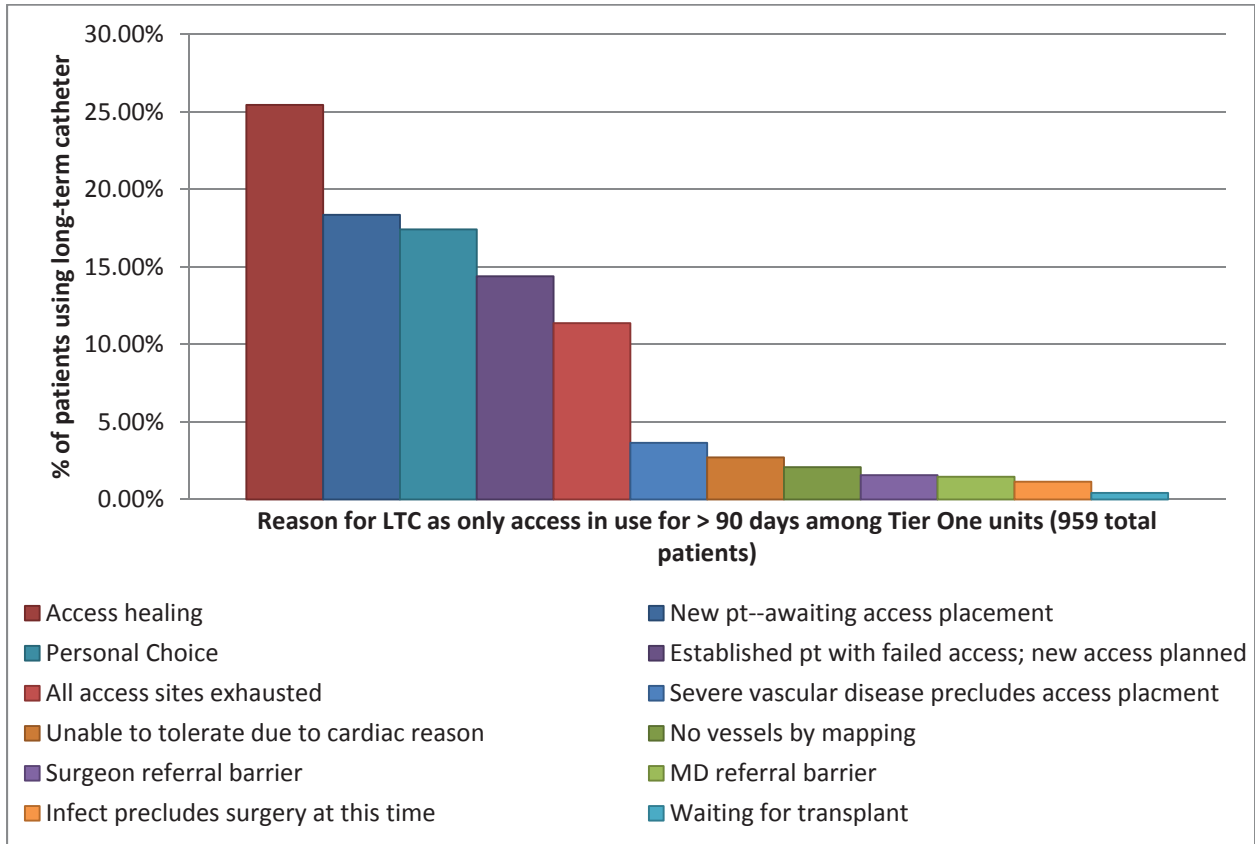
Ensuring accurate and timely data collection, analysis, and reporting by facilities in accordance with national standards.

## **Vascular Access Quality Improvement Activity (QIA)**

Network 8 began interventions to reduce rates of long term catheter (LTC) use (defined as catheters in use for  $\geq 90$  days) with 156 facilities in February 2016. Facilities were divided into two tiers, as determined by October 2015 LTC rates. Facilities with LTC rates  $\geq 15\%$  (n=68) were assigned to Tier One and were required to complete and submit root cause analyses (RCAs) for high LTC rates, and received monthly coaching calls from the Network Quality Improvement (QI) director with provisions of data reports as available. Facilities with rates  $> 10\%$  but  $< 15\%$  were assigned to Tier Two (n=88). Tier two facilities were monitored but did not receive monthly communication unless rates exceeded 15% for three consecutive months.



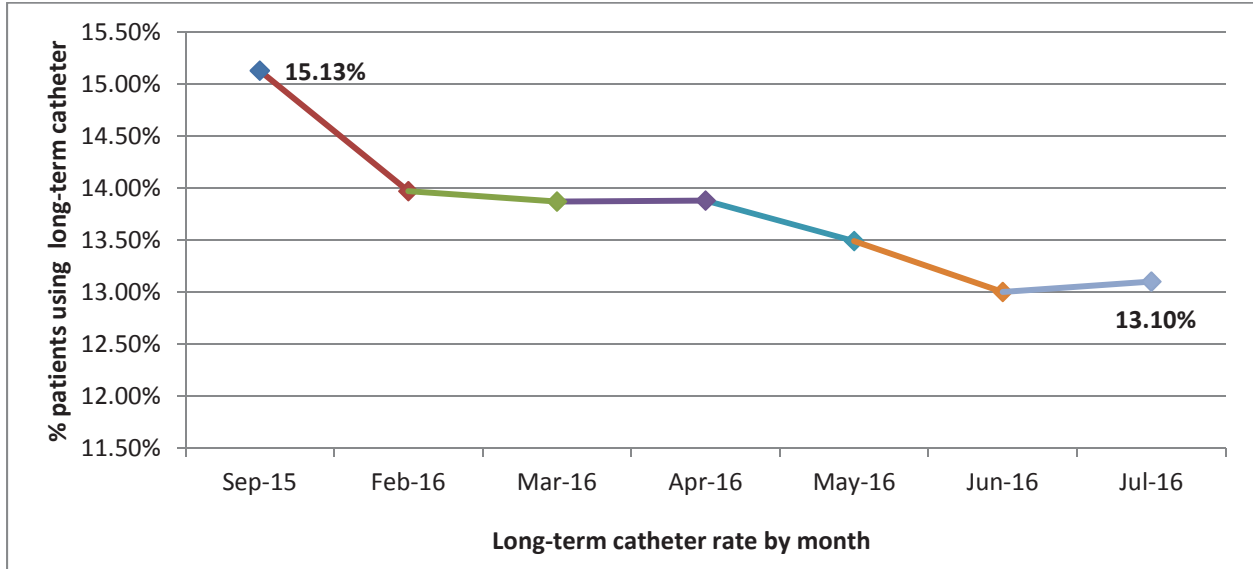
**Figure 1. Reasons for long-term catheter use in Network 8 Tier One units**



Monthly coaching calls to Tier One units included a patient-specific review of all patients dialyzing via central venous catheters (CVCs), with discussion of current facility interventions as well as additional resources and interventions that have proven helpful in other clinics such as physician review of maturing accesses each week, weekly review of access plan for new patients who were waiting for access consult/surgery, and early education and intervention for newly admitted patients to minimize use of CVCs.

Because of acknowledged data issues, monthly coaching calls were most often done with raw data pulled from CROWNWeb for rapid cycle improvement purposes. While there are differences between the official CROWNWeb dataset from the ESRD National Coordinating Center (NCC) and raw data from CROWNWeb, we successfully met the project goal of a two percentage point decrease in the LTC use rate (an absolute decrease of 150 catheters) by July re-measurement.

**Figure 2. Long-term catheter rate reduction in Network 8 project facilities**



Source of data: CROWNWeb as supplied by the ESRD National Coordinating Center

Over the course of this activity, various interventions were implemented by nurse managers and/or vascular access coordinators to ensure both sustained improvements and further reductions in long-term catheter rates. Successful interventions included:

Focus on catheter last—if the patient is a marginal candidate for arteriovenous fistula (AVF) request arteriovenous graft (AVG) placement initially so that the patient is not exposed to catheter use for months on end.

Use a team approach to catheter reduction. Use social workers to help determine why the patient refuses AVF or AVG and then use the social worker’s skillset to work with patient to see if this can be changed.

Schedule all new patients for access creation within one week of admission—provide appointment reminder to patient one week prior to appointment; ensure staff is also reminded of appointment so that patient can be encouraged to keep appointment as scheduled. Don’t let any patient “fall between the cracks.”

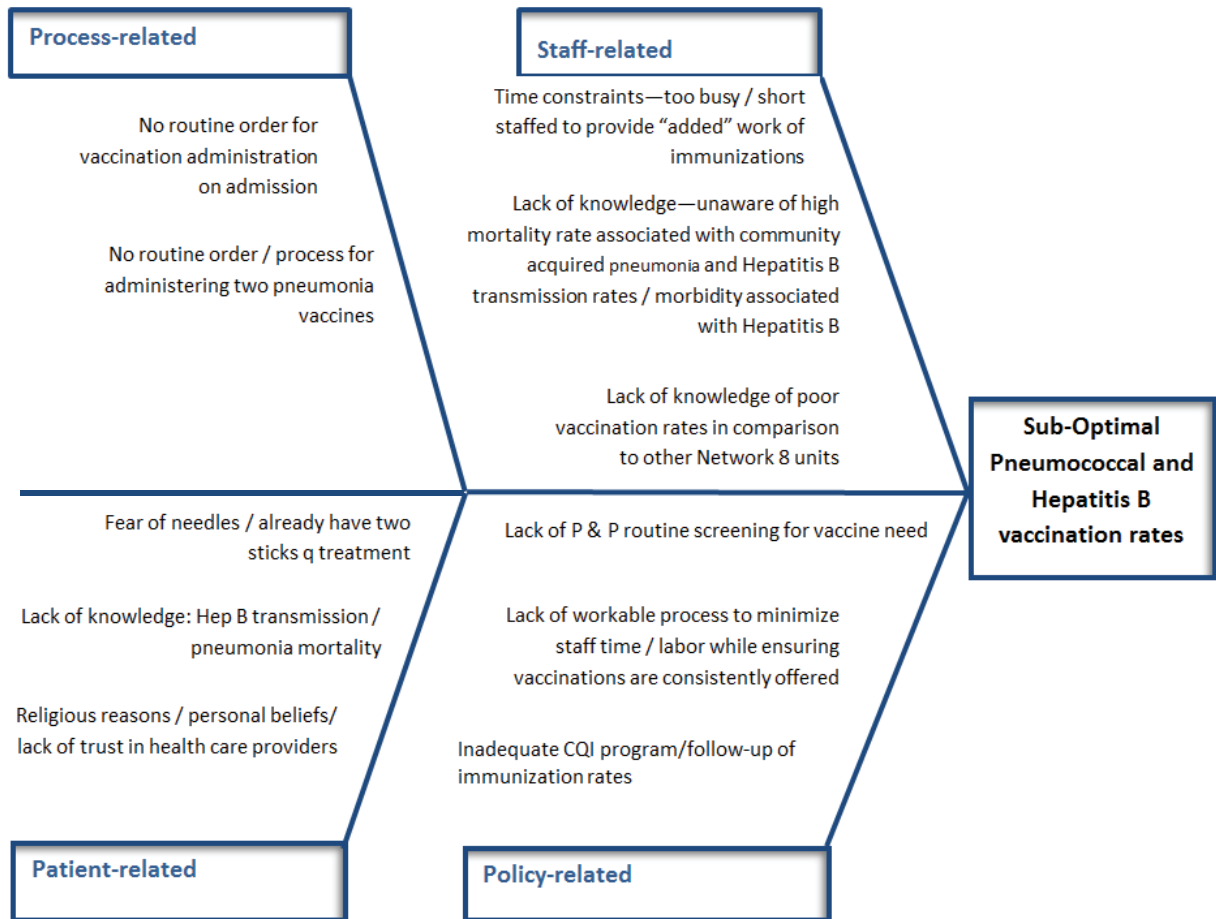
Conduct routine meetings every other week among the surgeon, nephrologist, nurse manager, and vascular access coordinator with special focus on catheter patients.

Consider peritoneal dialysis as an option for patients who are catheter-dependent.

### **Improving Vaccination Awareness and Administration Quality Improvement Activity**

Vaccination improvement interventions began with 25 facilities in March 2016. Vaccination data, provided by the NCC, was reviewed monthly and both patient and staff educational materials were provided during the course of the project. As of September 2016 data, 10 facilities had achieved vaccination rates  $\geq 60\%$  for both hepatitis B and pneumococcal disease; the remaining 15 units will remain in the project until vaccination rates reach or exceed 60% for each vaccination type. Barriers to vaccination, as determined via extensive literature review, were recorded in the following diagram.

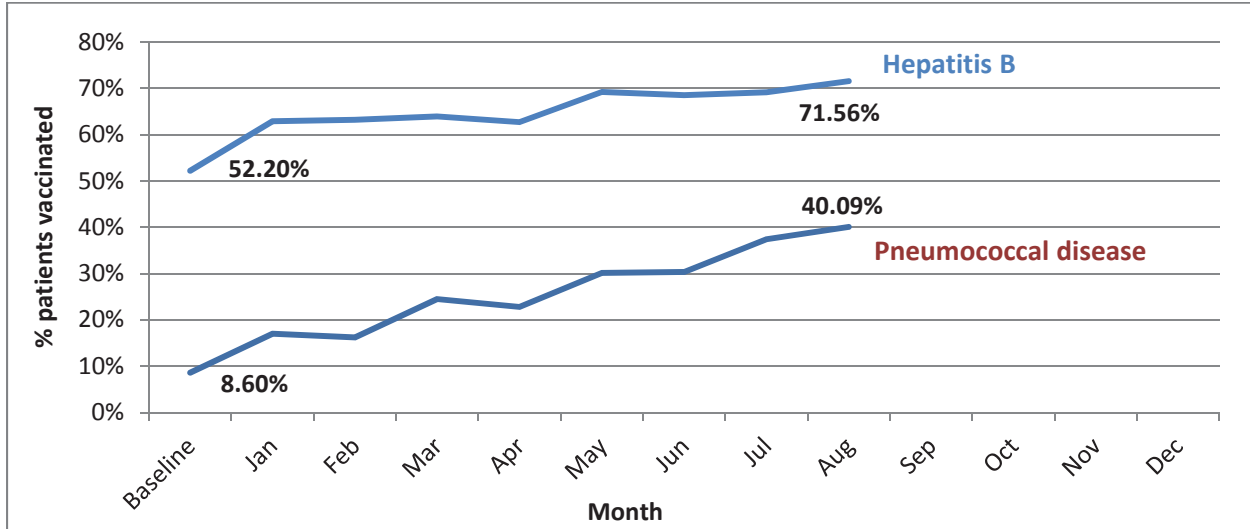
**Figure 3. Common barriers to vaccination**



Patient and staff education materials were distributed in May, June, August, and September. These materials addressed staff- and patient-related root causes; policy- and process-related barriers were not a common occurrence in facilities owned by large dialysis organizations. Though all units participating in the project were aware of internal facility vaccination rates, 50% of units that responded to the project evaluation stated they were unaware of vaccination rates < 60% as recorded in CROWNWeb.

Though there were discrepancies between facility-level and CROWNWeb datasets, we were able to exceed the project goal of a two percentage point increase for each vaccination type by August 2016, as reported in an NCC dataset received November 4, 2016.

**Figure 4. Improvement trend, Network 8 vaccination project 2016**



Source of data: CROWNWeb as supplied by the ESRD National Coordinating Center

### Healthcare-Associated Infections QIA

Network 8 developed a QIA that included 20% of Network-area dialysis facilities. The QIA was implemented in April 2016, and 86 facilities were selected to participate in the project. Selection criteria was based on facilities with the highest bloodstream infection (BSI) rates, as reported to the National Healthcare Safety Network (NHSN) from January 1, 2015, through June 30, 2015.

Target facilities performed the following monthly audits, using CDC audit tools, and reported the summary data to NHSN.

- 20 hand hygiene observations
- 10 catheter connection/disconnection observations
- 10 fistula/graft cannulation observations.

Interventions utilized CDC-developed tools and education resources located on the CDC website. These included:

- BSI prevention materials
- Core Interventions for Dialysis BSI Prevention
- Protocols, checklists, and audit tools
- Video: “Preventing BSIs in Outpatient Hemodialysis Patients: Best Practices for Dialysis Staff”
- Infection Prevention in Dialysis Settings Continuing Education course
- Patient Pocket Guide: “6 Tips to Prevent Dialysis Infections”
- Patient Flyer: “It Only Takes a Minute to Check Your Catheter”

On a monthly basis, BSI data was reviewed in order to assess infection trends. Target facilities that reported an increase of BSIs for two consecutive months were required to perform a RCA and develop an action plan that addressed specific challenges identified. By the conclusion of the QIA, analysis of the BSI rates reported in NHSN for the target facilities showed that BSIs

decreased from 1.43 BSIs per 100 patient months to 0.90 BSIs per 100 patient months, a decrease of 0.53 percentage points, or 37%.

When compared to the non-target facilities, target facilities had a significant decrease in BSIs from baseline to re-measurement. The target facilities' BSI rates decreased on average by .67 while the non-target facilities BSIs increased on average by .22 from baseline to re-measurement.

## **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 Network's CMS contract and for their performance on a number of quality metrics. Facilities that fail to comply with Network requests have the potential to be placed on the Network Watch List, the first in a sequence of steps that may lead to a request for sanction by CMS. The Network monitors these facilities and develops an action plan for improvement. Facilities are provided a timeline for completing activities in order to be removed from the Watch List. Networks may recommend that sanctions or alternative sanctions be imposed on facilities that do not cooperate in meeting Network goals or Conditions for Coverage. In 2016, no providers consistently failed to cooperate with Network goals.

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

Network 8's service area experienced 18 new openings and one facility closure in 2016. The increase in facilities appears to be aligned with the patient population and the treatment modalities of patients. The Network has not identified a specific need for additional facilities in the service area.

## **Contributions to the Professional Literature**

Avery, N., Leggett, S., & Juncos, L. (2016). Strengthening chronic kidney disease knowledge among students attending a historically black university. *Journal of Nephrology Social Work*, 40 (2), 38-43. <https://www.kidney.org/professionals/CNSW/JNSWOnline/v40B>

Muleta, D.; Kainer, M., Moore-Moravian, L., Wiese, A, Ward, J., McMaster, S., Nguyen, D., Forbi, J, Mixson-Hayden, T., & Collier, M. (2016). Hepatitis C outbreak in a dialysis clinic — Tennessee, 2014. [https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a5.htm?s\\_cid=mm6450a5\\_w](https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a5.htm?s_cid=mm6450a5_w)

## Grievances and Access to Care

Network 8 works with individual patients and facilities to identify and address difficulties in placing or maintaining patients in treatment. These access-to-care concerns may be presented to the Network in the form of a grievance or an at-risk access to care case initiated by facility staff. At-risk access to care cases involve patients in danger of being discharged from the facility.

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 consent. An involuntary transfer occurs when the patient is assigned to another dialysis facility not by their own choosing. This includes situations in which a patient was provided a 30-day notice of discharge, but was transferred before the last scheduled day of service to another dialysis provider. 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.

The Network responds to grievances filed by or on behalf of ESRD patients in its service area. In 2016, the Network responded to 104 grievances (Table D). Of these, 12 (12%) involved issues related to access to care. Of the 104 patient grievances, a majority were addressed using Immediate Advocacy (n=65). Immediate advocacy cases are simple, generally non-quality of care cases that can be completed in seven calendar days or less.

**Table D. Grievance Data for Calendar Year 2016**

Category	Number
Number of Grievance Cases Opened by the Network in Calendar Year 2016	104
Number of Grievance Cases Involving Access to Care	12
Number of Grievance Cases Involving Involuntary Transfer	0
Number of Grievance Cases Involving Involuntary Discharge	0
Number of Grievance Cases Involving Failure to Place	21
Number of Non-Grievance Cases Involving Access to Care	291
Number of Non-Grievance Cases Involving Involuntary Transfer	7
Number of Non-Grievance Cases Involving Involuntary Discharge	28
Number of Non-Grievance Cases Involving Failure to Place	18
Total Number of Grievance and Non-Grievance Cases Involving Access to Care	303
Number of Grievance Cases Closed by the Network in Calendar Year 2016	101
Number of Non-Grievance Access to Care Cases Closed by the Network in Calendar Year 2016	272

Source of data: Patient Contact Utility

Networks use a Patient Contact Utility (PCU) to record and monitor grievances, which are classified into one of four categories (Table E). Network 8 received 14 General Grievances. A general grievance does not entail clinical quality of care issues, but is more complex than a grievance that is appropriate for Immediate Advocacy and thus cannot be resolved within seven

calendar days. An Immediate Advocacy case that cannot be completed in the allotted time is reclassified as a General Grievance case.

Thirteen grievances were classified as Clinical Quality of Care Grievances. These grievances allege that a facility did not meet professionally recognized standards of clinical care. Clinical Quality of Care cases may be either 1) a patient-specific case, in which one patient is impacted, or 2) a general case, which two or more patients at a facility are impacted.

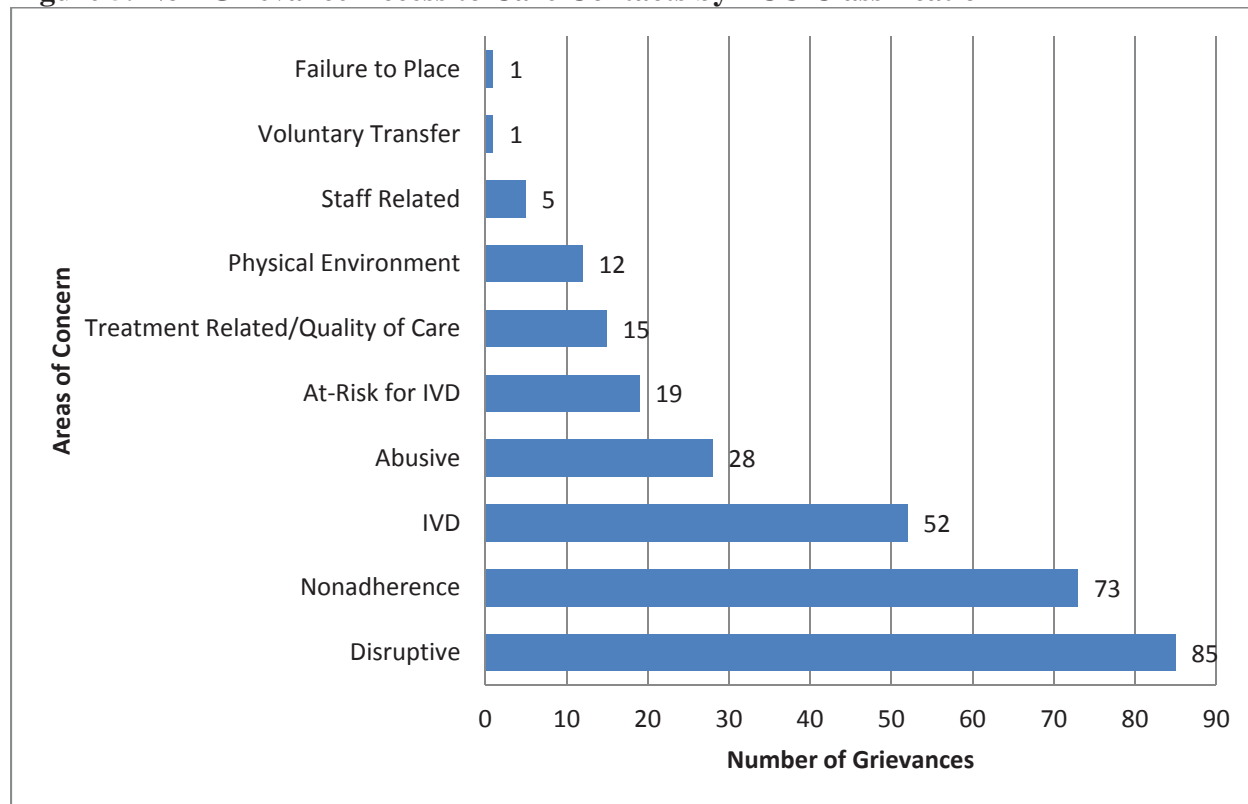
**Table E. Grievances Processed in 2016 by Patient Contact Utility Classification**

	Patient-Specific Quality of Care	General Quality of Care	Immediate Advocacy	Access to Care
Abusive	0	0	1	1
Disruptive	0	1	1	4
Non-Adherence	0	0	0	1
Physical Environment	0	0	4	0
Staff-Related	0	6	22	0
Treatment-Related	13	7	37	5
Voluntary Transfer	0	0	0	1

Source of data: Patient Contact Utility

As reflected in Figure 5, there were 291 non-grievance access-to-care cases in 2016. These calls are initiated by a facility staff, physician, hospital staff, or other professional requesting assistance addressing patient specific issues. The primary areas of concern for access-to-care calls were categorized as follows: 85 disruptive patient behaviors, 73 nonadherence to treatment, 52 involuntary discharge, 28 abusive patient behaviors, and 19 at-risk for involuntary discharge. Smaller categories include treatment related/quality of care, physical environment, staff related, voluntary transfer, and failure to place.

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



Source of data: Patient Contact Utility

When the areas of concern are related to involuntary discharge or disruptive/abusive behavior, the Network’s Patient Services Director (PSD) initiates a thorough review of the case and provides interventions to assist the facility in addressing the behavior in an effort to avert an involuntary discharge. When an involuntary discharge occurs, facilities are required to provide detail documentation and information for review. All facility administrators, nurse managers, and social workers were provided an involuntary discharge guide from the Network that outlined the required paperwork and reinforced involuntary discharge as a last resort.

The implementation of early interventions has proven a success in Network 8’s service area, with an increase in averted involuntary discharges. Patients who are involuntarily discharged often experience difficulty locating a new facility and are forced to receive 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.

All dialysis facilities in Network 8’s service area have been advised to notify the Network prior to providing the patient with a 30-day notice of discharge, and efforts are made to avert the discharge during the initial phone call with facility staff. The initial phone call consists of a review of facility interventions to improve the behavior and development of a detailed action plan. Additionally, the PSD reviewed the Medicare regulations with the facility and ensured that



guidelines had been followed. Of the 87 potential involuntary discharges reported to Network 8 in 2016, 60 (69%) were averted.

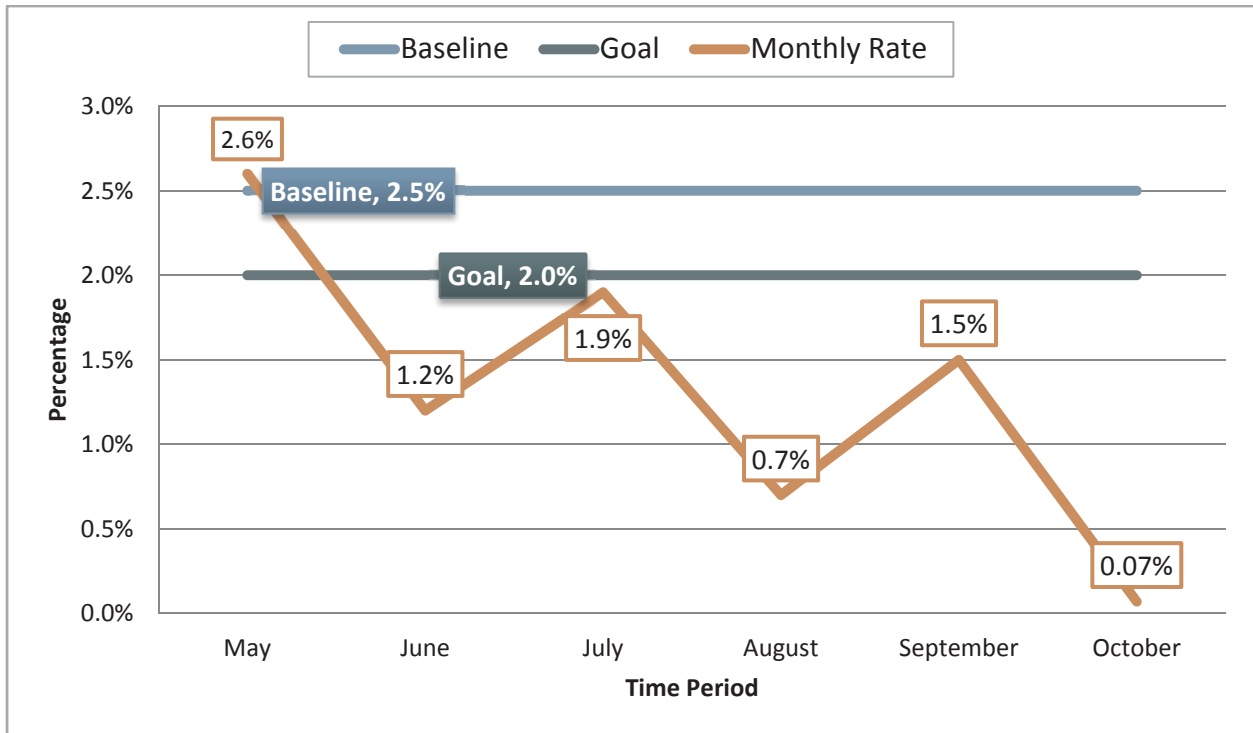
## **Grievance QIA**

The aim of the grievance QIA was to promote and improve the utilization of the grievance process at the facility level and to improve communication among patients, facility staff, and Network 8. Facility participation was based on a focused audit of the PCU data for 2015. Facilities with the highest number of grievances and access to care issues were selected for participation. Project participants included 6 Alabama dialysis facilities units, 2 Mississippi dialysis facilities, and 2 Tennessee dialysis facilities. Staff and patient educational materials were provided based on the results of an RCA and in collaboration with Network 8 Patient Advisory Council members.

At the facility level, 100% of the participating facilities identified a facility patient representative and staff project champion to collaborate in educating patients and staff about the grievance process. Each facility implemented an action plan that integrated the patient perspective. Monthly, each facility submitted grievance logs for scoring and reviewing. Over time, when a grievance trend was identified, coaching and educational materials were provided to address the grievances. One of the most successful interventions was the use of brief recorded educational modules that focused on professionalism and boundaries in ESRD and improving patient and staff communication. Based on intervention facility feedback, 100% of respondents agreed that the educational modules provided helpful information and 71.43% were incorporating the modules into routine staff education.

Monthly, the Network reviewed and scored the project facilities' grievance logs utilizing a CMS five-point scale. The scale scored grievances based on severity and category. The goal of the project was to decrease the average grievance score of all facilities by 20%. The project was measured by the total grievance score from all project facilities (numerator) and the number of project facilities (denominator). As demonstrated in Figure 6, by the conclusion of the QIA, Network 8 exceeded the overall grievance ratio goal of 2.0% with a final grievance ratio of 0.07% which indicates an overall decrease in facility grievances.

**Figure 6: Grievance QIA Ratios**



### **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 2016. The first case involved multiple quality of care issues identified by the patient's family. Specifically, the family felt their family member was being mistreated and had previously involved Adult Protective Services. The State Agency visited the facility and found that rules and laws were violated. The second referral was regarding a patient who suffered stroke symptoms after a dialysis technician used a hand crank on the back of the dialysis machine to return the patient's blood. The State Agency deemed the incident as misuse of medical equipment. The third referral was due to Network findings of significant declines in a patient's hemoglobin, without proper Epogen administration. When the State Agency investigated the grievance, it was not substantiated.

## **Emergency Preparedness and Response**

In January 2016, Winter Storm Jonas blanketed a large portion of Tennessee, bringing significant amounts of snowfall and icy conditions, and prompting the Tennessee Department of Emergency Management to declare a state of emergency. Beginning Friday, January 21, a series of unusual weather events caused the storm to sweep across western and central portions of the state with unusual speed and strength, with snow reaching Nashville by 6 a.m. Tennesseans were urged to stay home and avoid travel unless it was absolutely necessary as the snow that fell on Friday melted and refroze overnight, leading to dangerous and icy conditions into Saturday morning.

The storm impacted 35 facilities in Network 8's service area from January 21, 2016, through January 24, 2016. Throughout the event, Network staff remained in contact with affected facilities. Facilities implemented their emergency plans and made schedule adjustments in advance to accommodate dialysis needs. Network staff confirmed four facility closures as a result of Winter Storm Jonas. The Kidney Community Emergency Response (KCER) program, which serves as the leading authority on emergency preparedness and response for the kidney community, was on standby throughout the event, and Network 8 communicated with KCER and CMS on updates and changing conditions.