

ESRD Facility Handbook

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Special points of interest:

- Once certified, your facility will be required to utilize CROWNWeb, which is CMS' system of record.
- Your patients may bypass your internal grievance process and contact the Network or state directly.
- A Facility Patient Representative (FPR) is a great way to begin engaging your patients in their care.
- Once certified, your facility will be required to update EMResource, which is used in emergency/disaster situations.

ESRD Network of Texas, Inc. Facility Handbook Overview

This handbook has been compiled to assist your dialysis facility in understanding the role of the ESRD Network and the requirements of your facility to the Network under state and federal regulations. The handbook is designed to:

- Introduce the Network and its role in the ESRD Program, as well as its goals and objectives
- Inform of data accuracy and timeliness reporting requirements
- Describe the Network's patient grievance process
- Help devise/revise and implement a comprehensive and reliable disaster/emergency plan
- Facilitate the use of internal quality monitoring and improvement
- Suggest methods for collaborating with patients to achieve desired outcomes
- Provide an overview of CMS-directed Network projects in which your facility may be selected to participate

This document is prepared for use electronically with specific, clickable links to various information and resources. Information provided can be utilized in facility self-assessment, education, and in-service and can be incorporated into the Quality Assessment Performance Improvement Program (QAPI). The appendices mentioned in the handbook can be downloaded separately on the Network's website.

The Network staff and the Medicare Review Board (MRB) are available to assist you in meeting your professional needs and the needs of your ESRD patients and their families and/or caregivers. Please contact us whenever we may help you.



END STAGE RENAL DISEASE
NETWORK OF TEXAS

Introduction to the Network Organization

WHO AND WHAT IS THE NETWORK?

The End Stage Renal Disease Network Organization Program (ESRD Network Program) is a national quality improvement program funded through the Centers for Medicare & Medicaid Services (CMS). 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.

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 healthcare 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.

Some Networks' geographic regions consist of several states, and some, like ESRD Network of Texas, Inc. (ESRD Network 14), consist of only one. For a map of the ESRD Network areas, please visit www.esrdnetworks.org or www.esrdncc.org. For more information on the ESRD Program, visit www.cms.gov and type "ESRD Networks" into the search tool or download the [Medicare End-stage Renal Disease \(ESRD\) Network Organization Program fact sheet](#).

What is the difference between the Network and the State Survey Agency?

Each state has an agency to ensure the health and safety of the state's residents. CMS contracts with these state agencies to perform surveys to ensure compliance with federal regulations, as well as the CMS Conditions for Coverage. In Texas, the state agency is the Texas Department of State Health Services (DSHS). Some states, including Texas, also have state laws and regulations for dialysis facilities that may exceed the requirements of the federal regulations. The DSHS surveyors, for compliance with both state and federal regulations, issue a state license and certify compliance with federal regulations to CMS for all dialysis providers in Texas (Appendix A). For more information, visit www.dshs.state.tx.us.

Introduction to the Network Organization (cont.)

NETWORK GOALS AND OBJECTIVES

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.

The ESRD Network contractors are 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
- 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

Additionally, as required by Sections 1881(c)(2)(B) and 1881(c)(2)(H) of the Social Security Act, the Network establishes goals for each facility that align with the CMS goals for the ESRD Network Program and that reflect the regional priorities as determined by the Network Council, the Board of Directors (BOD), the Medical Review Board (MRB), and the Patient Advisory Committee (PAC). These Network facility goals are:

- Continuously strive to deliver care to each patient that is patient- and family-centered, individualized, consistent with current professional knowledge, and that achieves desired outcomes, which include:
 - ◊ Meet the vascular access thresholds: Less than 10% of patients with a catheter in use greater than or equal to 90 days and greater than or equal to 68% of patients with an AVF in use for vascular access.
 - ◊ Achieve the CMS thresholds for the Quality Incentive Program (QIP) measures.
 - ◊ Meet other clinical thresholds as determined by the MRB annually.
- Assess and refer in a timely manner medically suitable patients to treatment modalities that increase habilitation and independence, including in-center self-care, home self-care, and transplantation.

Introduction to the Network Organization (cont.)

- Establish and maintain a dynamic quality assessment and performance improvement program that evaluates the care provided and identifies opportunities for and continuously works to improve the care delivered.
- Clearly delineate and respect the rights and responsibilities of **BOTH** the patient, family, significant others, **AND** the facility while promoting patient- and family-centered care and engagement.
- Submit data timely and accurately in CROWNWeb, as is required by law and regulation, which includes registering for QARMS timely and maintaining the roster of personnel and patient representatives. Facilities are expected to complete the following, including but not limited to, for ALL patients:
 - ◊ CMS forms
 - ◊ Vascular access data
 - ◊ Vaccination status
 - ◊ CROWNWeb data fields required by the QIP
- Submit data and project requirements timely and accurately for all Network AIM projects and/or CMS directives.
- Register in NHSN, enroll in the ESRD Network 14 group, and submit dialysis event data and information timely and accurately on a monthly basis.
- Utilize EMResource by completing the required provider information, updating monthly, and updating daily or more frequently when needed during emergency situations that disrupt dialysis delivery, as well as designate two disaster representatives for the facility and provide off-facility contact information.
- Appoint and support at least one Facility Patient Representative (FPR).
- Utilize the national Decreasing Dialysis Patient-Provider Conflict tools to educate staff.
- Make available to patients Network-provided information on its Quality Improvement Activities, the national QIP, the Annual Report, regional and national profiles of care, the importance of vaccination, information on how to access and use Medicare's Dialysis Facility Report, information on the CROWNWeb system developed by CMS, and other information as directed by project.
- Cooperate in meeting the Network Goals and Objectives delineated above as required by law and regulation (CfC 405.2134 Condition: Participation in network activities).

Introduction to the Network Organization (cont.)

QUALITY IMPROVEMENT

Network Quality Improvement Activities (QIAs) align with and support the CMS National Quality Strategy (NQS), and its Three-Part Aim of Better Care, Better Health, Lower Cost, and other CMS priorities designed to result in improvements in the care of individuals with ESRD.

The Network's role is to assist providers in assessing and improving the care provided to ESRD beneficiaries by identifying opportunities for quality improvement at the individual facility level and providing technical assistance, facilitating processes to promote care coordination between different care settings and ensuring accurate, complete, consistent, and timely data collection, analysis, and reporting by facilities in accordance with national standards and the ESRD Quality Incentive Program (QIP). Quality improvement is a continuous process using information from data on processes and outcomes to recognize opportunities to improve care and to develop measurable improvement initiatives. The fundamental purpose of these activities is to assist the providers in improving the care provided to ESRD patients.

Networks use the following Institute of Medicine definition: "Quality of Care is the degree to which health services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge."

When possible patient outcomes are analyzed by facility as compared to state and national outcomes, as well as to National Practice Guidelines and the QIP. The Network in Texas works with DSHS to provide technical assistance and MRB advice, as well as data and information on the quality of care that is utilized by both agencies to make determinations regarding the quality of care delivered by facilities.

Currently, most routine data needed for the work of the Network is submitted by each provider into the CROWNWeb or NHSN databases either electronically or manually. Projects performed; however, may require collection of data from providers that is not available in CROWNWeb. We make every effort to provide advance notice, clear and concise directions, and an identified contact person for these activities. The facility must submit the requested data and information in a timely manner to fulfill the regulation to participate in meeting Network goals and objectives and to submit timely and accurate data to administer the ESRD Program (see the Compliance Policy, Appendix B).

INFORMATION MANAGEMENT

ESRD Program data are used by each Network's MRB, federal and state agencies, and renal-related organizations to make informed decisions about treatment options and healthcare policy. The submission of **timely and accurate data** by facilities directly contributes to the success of the United States Renal Data System (USRDS). The Information Management Section of the handbook describes the required CMS forms submission of a Medicare approved provider of ESRD services and training offered by the Network.

Introduction to the Network Organization (cont.)

PATIENT SERVICES

Each new ESRD patient receives a New Patient Packet at his or her home address that includes the book *You Can Live* and other helpful information. ESRD patients have direct access to the Network for problems related to the quality of their treatment through the grievance resolution mechanism. **ESRD Network 14 has a toll-free line *FOR PATIENTS ONLY* at 877-866-4435.**

A **Patient Advisory Committee (PAC)** is maintained to advise the Network on patient issues, and each facility is requested to recruit at least one Facility Patient Representative (FPR) to serve as a liaison between the patients, the facility, and the Network. A link to the **FPR Toolkit** is provided in the Patient Engagement section. ESRD Network 14 has conducted activities regarding dealing with challenging patients that include professional and patient education, developing a booklet, and collecting event data about involuntary discharges. The Network is very concerned that immediate discharges be avoided except in the case of truly threatening, lethal behavior. You should have already received the CMS-sponsored national Decreasing Patient-Provider Conflict (DPC) Project Manual, CD, and tools in your New Facility Packet. It is strongly recommended that the DPC program be totally implemented in your facility.

Network staff with experience in ESRD care is available to facilitate understanding and provide education and advice in areas of concern between patients, providers, and professionals.

ORGANIZATIONAL STRUCTURE

In addition to the Network staff, there are three primary committees: the Network Council, Board of Directors, and the Medical Review Board (Appendix C). Please feel free to access our website at www.esrdnetwork.org for a current staff listing. The key Network staff positions are the Executive Director, the Quality Improvement Director, the Patient Services Director, and the Outreach Coordinator. Geographic representation from across the state is sought in the Network committees. Additionally, ESRD Network of Texas, Inc., is a subsidiary of [Alliant Health Solutions \(AHS\)](#) and, in conjunction with ESRD Network 8, is part of the [Alliant Quality Kidney Collaborative \(AQKC\)](#).

For more information on the Network committees, please see our website at www.esrdnetwork.org.

MISSION AND VISION STATEMENTS

Mission

We support equitable patient- and family-centered quality dialysis and kidney transplant health care through patient services, education, quality improvement, and information management.

Vision

We will foster engaged patients and families that receive high quality and safe patient/family-centered care in welcoming environments for patients and family.

Information Management

Completion and submission of the data described in this section is **required by law** in Section 405.2133 of Subpart U of the Code of the Federal Regulations: “Condition: Furnishing data and information for ESRD program administration. The ESRD facility furnishes data and information in the manner and at the intervals specified by the Secretary, pertaining to its ESRD patient care activities and costs, for inclusion in a national ESRD medical information system and in compilations relevant to program administration, including claims processing and reimbursement. Such information is treated as confidential when it pertains to individual patients and is not disclosed except as authorized by Department regulations on confidentiality and disclosure.”

All Medicare-certified dialysis facilities must furnish this data through the CROWNWeb database, which requires that all Medicare-certified dialysis facilities must have access to this database. Information on how to obtain access can be found on the [QualityNet website](#).

Within CROWNWeb, facilities have specific actions to perform, which include submitting required CMS forms (2728s, 2746s, and 2744s), entering/verifying monthly clinical data, verifying/maintaining the Patient Attributes and Related Treatment (PART), and entering/maintaining an accurate personnel listing. Specific CMS-regulated actions and deadlines can be found in the [CROWNWeb Data Management Guidelines](#).

Help guides and training materials for all of these aspects of information management can be found on the [ESRD Network 14 CROWNWeb page](#) and CROWNWeb’s official education website, www.mycrownweb.org.

Patient Services

The Network Patient Services Department strives to provide information and assistance to patients, families, caregivers, facility staff, and professionals.

PATIENT’S RIGHTS AND RESPONSIBILITIES

A Network statement of Patient Rights and Responsibilities is included in Appendix D. Please review this statement and compare with your facility statement of rights and responsibilities. If major differences are noted, the facility Governing Body should consider any applicable revisions. *Because You Count*, a video that focuses on the patient’s rights and responsibilities and teaches patients how to take an active role in their health care, is available [online](#). A DVD copy can be sent to the facility upon request.

GRIEVANCES

The mission of the department is to assist patients, caregivers, and families in resolving concerns when a grievance is received. The Network will encourage the patient or his/her representative to work with the facility whenever possible; however, the patient is not required to do so. The role of the Network in prevention and resolution of grievances varies depending on the situation. The Network may assume any of the following roles: expert investigator, facilitator, educator, referral source, advocate, or QI specialist.

Patient Services (cont.)

Many calls received by the Network are resolved by providing education or by facilitating communication between the facility and patient. As is true in all relationships, miscommunication and misunderstandings occur that create conflict for all the involved parties in the ESRD setting. In most cases, the facility **Social Worker**, utilizing his/her skills as a trained MSW, along with the interdisciplinary team should be able to handle these situations without the need for Network involvement.

When a grievance is received, the Network must follow several steps as outlined by CMS. The entire investigation should be completed within 60 days and may involve the MRB and/or the Patient Advisory Committee (PAC). Should the investigation determine that an Improvement Plan (IP) be required, the Network will notify the facility with written instructions regarding the development of the IP and the required timeline. Cases that do involve quality of care and that can be resolved within 7 days may be handled under Immediate Advocacy. Non-Grievance access to care cases are also handled by the Network.

When several grievances or a single grievance from several patients is received, the Network considers that the facility has a pattern of grievances. In these instances the Patient Services Director will contact the facility administrator to alert him/her of this pattern and to discuss possible causes and solutions. If such grievances are received regarding the quality of care, the Network Quality Improvement staff will initiate the contact and determine whether the MRB will be involved. Occasionally, a site visit will be scheduled.

GRIEVANCE POLICY AND PROCEDURE

An effective patient grievance procedure must be implemented and maintained if patients' rights are to be supported. The Network currently has a Patient Grievance Procedure. Section 9335 of Public Law 99-509, the Omnibus Budget Reconciliation Act of 1986 (OBRA), Section 9335 (F)(5) of the Social Security Act, requires that the ESRD Network implement a procedure for evaluating and resolving ESRD patient grievances. Federal regulations (42 CFR Section 405.2138) require all facilities to inform patients of their rights and responsibilities, including the grievance process.

The Network may receive a grievance from a patient, designated patient representative, family member, friend, facility employee, physician, state agency, patient advocate, interested citizen, or newspaper. Grievances may concern services provided in dialysis units, nursing homes, transplant centers, acute care hospitals, home setting, or a physician's office, but **must** be specifically related to ESRD services. Referrals may also be received from several government agencies. Grievances about a reimbursement or survey and certification issue will be immediately referred to the Associate Regional Administrator, Division of Health Standards and Quality, at the CMS Regional Office.

If a patient has a grievance or question regarding ESRD treatment, they may exercise their rights through the Grievance Procedure. This can be done by the patient or representative of his/her choice without restraint or interference and without fear of discrimination or reprisal. The procedure **must** be posted at all facilities. It is the policy of the Network that all grievances received will be given prompt and impartial

Patient Services (cont.)

consideration. The Network will provide the facility with an AQKC grievance poster in both English and Spanish with a concise grievance procedure.

Confidentiality will be maintained in all steps of the Grievance Procedure consistent with the Privacy Act. The patient will not be identified unless he/she specifically authorizes release. If the Network is unable to facilitate the resolution of the grievance without releasing the patient's identity, the patient will be immediately notified. If the patient still does not allow release, the Network will advise the patient in writing that it is unable to continue the process and outline other alternatives, such as referral to the Texas Department of Health or the CMS Regional Office, that are available.

If the grievance presented to the Network appears to be of an immediate life-threatening nature, it will be immediately forwarded to the CMS Regional Office, attention of the Associate Regional Administrator, Division of Health Standards and Quality, as well as DSHS.

Grievance Procedure

The Network is required to evaluate all grievances and non Grievance access to care cases. These may be received via telephone, fax or in writing. While not required, those received by phone are preferred to be followed by written documentation. The Network will make a thorough investigation, with acknowledgment provided to the patient within three calendar days of inquiry. All Network efforts for resolution should be concluded within 60 calendar days of inquiry. Written correspondence will be sent to the patient detailing the Network's efforts, results, and other options the patient may pursue, if applicable.

If the grievance presented to the Network appears to be of an immediate life-threatening nature, it is to be immediately forwarded to the CMS Regional Office, attention of the Associate Regional Administrator, Division of Health Standards and Quality, as well as DSHS. The initial contact will be via telephone, immediately followed by written confirmation. The patient shall be informed of this procedure.

It is the expectation of CMS and the Network that each facility have a fully functioning, safe and open process to address patient and family concerns and complaints, that is well known to patients and families. This process should be dynamic and easily identify and address, even prevent, systemic issues that cause concerns and complaints, such as long wait times, abrupt scheduling changes except in emergencies, environmental issues with heating and air conditioning, cleanliness and comfort. Staff turnover and lack of training in communication, professionalism, and cultural awareness are common triggers for patient and family grievances that can and should be addressed proactively at the facility level. Rapid acknowledgement and ongoing communication with the complainant is integral to a dynamic and effective complaint process. Finally, demonstrating respect of patient and family individual needs and preferences is patient-/family-centered and serves as an excellent foundation for the patient-family-facility relationship.

Patient Services (cont.)

If a mutually agreeable settlement is not reached through the Network's efforts and assistance, the patient may contact the CMS Regional Office. Direct all calls and correspondence to:

Centers for Medicare & Medicaid Services
Administration Regional Office
Attention: Associate Regional Administrator
Division of Health Standards and Quality
1301 Young Street
Dallas, Texas 75202
214-767-6427

WORKING WITH CHALLENGING PATIENT AND/OR FAMILIES

The Network developed and disseminated the *Intensive Intervention with the Non-Adherent Patient* booklet to assist facilities in working with non-adherent patients. You can download this booklet from the [ESRD Network 14 Patient-Provider Conflict page](#). It is recommended that this booklet be referenced early in the process of intervening with a non-adherent patient. **The Network and the MRB do not support the involuntary discharge of patients for non-adherence and it is not an approved reason for discharge under the CfC.** The Network feels that use of the tools and techniques outlined in this booklet will successfully resolve many situations.

The Network has also included the *Decreasing Patient-Provider Conflict Toolbox: Conflict Resolution Resources for the Dialysis Professional* and the grievance posters in the New Facility Packet.

Use of a Behavior Agreement is also frequently successful in working with difficult situations; however, the Network encourages an approach that is articulated in the article *The Behavior Contract as a Positive Patient Experience*, also available on the [Patient-Provider Conflict page](#).

We encourage staff to contact the Patient Services Director for phone consultations when needed.

Emergency Preparedness

All dialysis facilities should place patient and staff safety as a high priority. Per federal and Texas Department of Health ESRD facility licensing rules, facilities should have an emergency management plan in place to meet the specific hazards that may impact the facility.

Each facility's emergency management plan should establish specific measures that will minimize risk to lives, enable the facility to prevent and/or minimize damages, and quickly resume operations, using internal resources and expertise. A plan should include provisions to:

- **Ensure the safety** of employees and patients
- **Train all dialysis employees and patients** to react appropriately in an emergency, whether at work or home

Emergency Preparedness (cont.)

- **Expedite the resumption of dialysis operations** for the patient population following an emergency
- **Encourage planning and sharing of resources** (human, equipment, facilities and supplies) with other medical care facilities in the area during and following an emergency
- **Review and make necessary (reasonable) changes** to buildings, systems, and equipment to ensure the integrity of structures and services

Emergency Management Planning—Where to begin?

An emergency is any unplanned event that can cause deaths or significant injuries to employees, patients or the public, or that can shut down the facility, disrupt operations, and cause physical or environmental damage. The following basic steps are recommended as emergency planning commences:

- **Check with other local area dialysis and healthcare providers.** The Network supports the work developed by TEEC, a community-based coalition comprised of local providers, professionals, and state representatives.
- **Contact your state Office of Emergency Services (OES).** In most cases, they can provide a list of county emergency management offices and local utility companies for your area. You can access the [Texas Division of Emergency Management website](#) for a list of the offices around the state. A sample letter to a local OES is in Appendix E.
- **Contact the Network office or check the [Network](#) and/or [TEEC](#) websites.**
- **Check EMResource for updates, documents, and information.** Remember to log onto [EMResource](#) for the latest information and updates during an emergency or disaster. If you do not have access to a facility log in, please use the **view only** login information found on the [Network website](#). EMResource is also available as a smartphone application.
- **Contact local City EOC and RAC offices to see when they meet and plan to attend at least one meeting.** Each Regional Advisory Council (RAC) region meets with key personnel from the Emergency Operations Center (EOC), hospitals, and city officials (police and fire) to discuss emergency planning and drills and determine the needs of the region. Each city usually has an EOC. Each county has an EOC and often an OES. These groups are responsible for the distribution of services and resources in an affected area. The City EOC is expected to handle its own emergencies. However, if it is beyond its capabilities and it has exhausted its resources, it then goes to the County EOC. If the County EOC has exhausted its resources, it goes to the State EOC and then the Federal Emergency Management Agency (FEMA) as a last resort. Chronic treatment centers such as dialysis units are not normally included in emergency plans. **That is why it is critical that you notify your local office of your needs.**
- **Contact your county Emergency Medical Services (EMS) agency.** Many EMS agencies have disaster councils and other committees who deal with at-risk and disabled populations during a disaster. This may be a good entry point to get your facility included in the county medical emergency plan. This includes contacting [211 Texas](#), to register all patients that would require assistance during an evacuation.

Emergency Preparedness (cont.)

- **Develop a facility plan.** Each facility is required to have a plan, which is comprehensive, and individualized to the threats in your geographic area. Visit the [TEEC website](#) to view a Disaster Plan Checklist to ensure your plan has all the required components.
- **Form a disaster planning team.** This could consist of the administrator, nurse-in-charge, chief technician, and an administrative person. Review the entire plan before starting to get a sense of the information and the work involved. Then divide up logical sections to each team member. The leader of this team should be listed as the primary emergency contact in EMResource. Schedule regular update meetings to help motivate team members and keep them on track. Remember this is an ongoing process; it is never done!
- **Review your plan and compare the elements in it to those included in emergency management resources.** The [Network](#) and [TEEC](#) websites have resources for you to download and use in your facility.
- **Determine which areas are the highest priorities for your facility (or corporation) to modify or develop.**
- **Draw up a timetable and checklist for implementation.**
- **Include in the first phase some activities that are easy to bring to completion so that everyone can celebrate successes right away.**
- **Rank the rest of the elements or topics and plan implementation over time.**
- **Keep emergency preparation supplies on hand.**

A good plan takes time to develop, review, modify, and implement. Take the time you need, and do it right the first time. To assist with this planning, two emergency management resources are available on our [website](#) to download: *Preparing for Emergencies—A Guide for Chronic Dialysis Patients* and *Preparing for Emergencies—A Guide for People on Dialysis*.

DISASTER PREPAREDNESS: VIDEO FOR PATIENTS

TEEC with the ESRD Network 14 has created a disaster preparedness video for patients in both English and Spanish. The creation of the video was made possible by Fresenius Medical Care North America. It is intended for dialysis and transplant patients. TEEC recommends that the video be shown to patients at least annually and prior to the start of hurricane season. The video highlights disaster planning and preparedness for dialysis and transplant patients and includes information on the three-day emergency diet, State of Texas Emergency Assistance Registry (211), the READY Packet, patient wrist bands, and the clear disaster bags, as well as additional resources for patient disaster planning.

The video is available [online](#) and available for download for Windows Media Player on the ESRD Network 14 [Disaster Planning page](#). A DVD copy can be sent to the facility upon request.

Emergency Preparedness (cont.)

Before showing this video to patients, TEEC encourages staff members to view it and be prepared to answer patients' questions. ESRD Network 14 hopes that you and your patients find the video helpful as you continue to prepare for disasters.

For more information on disaster planning:

- Visit the [Texas Prepares website](#)
- Visit the [Kidney Community Emergency Response Coalition](#) website
- Contact [TEEC](#)
- Contact [ESRD Network 14](#)

Quality Improvement

WHAT IS QUALITY MANAGEMENT/IMPROVEMENT?

The Network uses the terminology of “quality management” (QM) to encompass the many aspects of the work done with and by dialysis facilities regarding delivery of quality care. Quality management consists of quality planning, quality control, and quality improvement.

Quality planning is the activity of developing the products and processes required to meet customers' expectations. Although you may think of only patients as your customers, we invite you to take a broader look (Appendix F). Quality planning is initially done at the Governing Body level; however, any time a new process is introduced into the facility, whether this is due to new equipment, new shifts, or new procedures, quality planning needs to be done. Quality planning involves a series of universal steps, as follows:

- Determine who the customers are.
- Determine the needs of the customers.
- Develop policies that respond to customers' needs (dialysis treatments and support services).
- Develop procedures that are able to produce these features.
- Transfer the resulting plans into operation (develop procedures and conduct training).

Quality control is the job of the Quality Committee. The Quality Committee is comprised of at least the Medical Director, Nurse Manager, Chief Technician, and Facility Administrator. Patient involvement on this committee is highly encouraged, and the patient(s) would be dismissed from the meeting when team discussions concerning patient-specific issues begin. The Quality Committee should meet monthly, at minimum, and review all the quality indicator data on key aspects of care as required by CMS and DSHS and as described in the [Network Criteria and Standards for Dialysis Facility Specific Quality Management Program](#). Quality control involves:

- Evaluating actual performance of the facility processes
- Comparing actual performance with quality goals
- Taking action on any difference between planned goals and actual performance

Quality Improvement (cont.)

Quality improvement (QI) is a process of continually striving to improve. Whenever the QM Committee notes that actual performance does not meet desired performance, QI should be initiated. The following are employed:

- Identify specific needs for improvement.
- Establish a Quality Team consisting of three to five people who actually work in the process that you are trying to improve.
- Provide the resources, motivation, and training needed by the teams to identify causes, plan changes, and then monitor for improvement. (The Network Quality Improvement Department is available for onsite or offsite training and consultations.)

Many approaches have been designed for use in Quality management/improvement. Most corporations have a QM/QI Manual that is a ready source of forms and instructions.

This brief introduction to QM programs may be all that is needed. If more intensive education and assistance is desired, please contact the Network Quality Improvement Department. Also visit our [Quality Improvement](#) and [Criteria and Standards](#) pages for more QI resources.

CMS ESRD QUALITY INCENTIVE PROGRAM (QIP)

The CMS ESRD Quality Incentive Program (QIP) is part of the CMS plan to reimburse dialysis facilities for treatments based on the quality of dialysis care they administer. Each facility receives a Total Performance Score (TPS), calculated based on clinical and reporting measures for which the facility is eligible, which is used to determine whether the facility receives full reimbursement for their services for Medicare patients or if the facility receives up to a 2% payment reduction. Please see our [QIP](#) page for more information and resources about the program and the current calendar year measures.

CROWNWEB CLINICAL/VASCULAR ACCESS DATA

Clinical data and lab values, as well as Vascular Access data, are required to be reported each month for every hemodialysis and peritoneal dialysis patient (regardless of payment type) who received dialysis treatment during the month. Your facility may be part of a Batch Submitting Organization (BSO) that electronically uploads the data, but upon certification, your facility has a responsibility to make sure that data are being completely and accurately uploaded into CROWNWeb. Please refer to the [CROWNWeb Data Management Guidelines](#) and resources on the [Network CROWNWeb page](#) and the [MyCROWNWeb training videos](#).

VASCULAR ACCESS RESOURCES

Please see our Vascular Access resources on our [Managing Vascular Access](#) page.

NATIONAL HEALTHCARE SAFETY NETWORK (NHSN)

The National Healthcare Safety Network (NHSN), which is managed by the Centers for Disease Control and Prevention (CDC), is a secure, internet-based surveillance system that collects and analyzes data from

Quality Improvement (cont.)

healthcare facilities in the United States, including outpatient dialysis facilities. CMS made NHSN reporting a measure on the QIP in 2012. Enrollment in this system is **mandatory**. Information on how to enroll and utilize the system can be found on the Network's [NHSN](#) page.

DIALYSIS FACILITY REPORT (DFR)

The DFR is prepared for each dialysis facility by the University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) with funding from CMS. The state survey agency receives a copy of this report and uses it during certification and grievance investigation surveys. Please see the DFR section of the [QIP](#) page for resources and more information.

5-DIAMOND PATIENT SAFETY PROGRAM

In 2008, the Mid-Atlantic Renal Coalition (ESRD Network 5) and the ESRD Network of New England, Inc. (ESRD Network 1) developed the 5-Diamond Patient Safety Program as an innovative training and recognition program to assist dialysis providers in increasing awareness and building a culture of safety among patients and staff. As patient safety and the quality of their care are essential components of ESRD Network 14's mission and vision, the Network adapted this program in 2011 and used it as a Network-specific quality improvement project that has now expanded to include all Texas facilities interested in participating.

The 5-Diamond Patient Safety Program consists of modules that include the tools and resources necessary to implement each patient safety concept. For each module completed during a program year, a facility earns one Diamond. Upon successful completion of five modules within a program year, a facility is recognized as a *5-Diamond Patient Safety Facility*. For more information, please see our [5-Diamond Patient Safety Program](#) page.

Patient Engagement

CMS and the ESRD Networks have an ever increasing focus on patient engagement and patient- and family-centered care, which revolve around the patients, family members, and caregivers becoming active participants in the decision-making process when it comes to healthcare decisions and the quality of their lives. The ESRD Network 14 website has many resources for both [patients](#) and [professionals](#) to use to promote and perform patient engagement and patient- and family-centered care.

ESRD Network 14 also has as a specific facility goal to appoint and support at least one Facility Patient Representative, a liaison between the facility staff and other patients in the facility, as well as between the facility and the Network. For more information and to download the toolkit, visit our [Patient Representatives page](#). Additionally, CMS requires each Network to recruit patient Subject Matter Experts (SMEs) to participate in the national Patient and Family Engagement Learning and Action Network (N-PFE LAN).

Exercise, Live Well, and Feel Better, a video that focuses on how exercise has improved the quality of life for dialysis and transplant patients, is available [online](#). A DVD copy can be sent to the facility upon request.

Introduction to Network Projects

The ESRD Networks are directed to help facilities improve the quality of care given to dialysis patients through the performance of projects that focus on increasing positive outcomes of certain measures, such as Vascular Access and Vaccination. Most of these projects are completed through or include Quality Improvement Activities (QIAs) that help identify and target specific issues within facility processes or communications and require facilities to execute Network-suggested or facility-produced solutions to improve outcomes.

CMS directs how Networks are to select facilities to participate in these projects, and your facility may be chosen to participate in the future. Some examples of QIAs that ESRD Network 14 has or is currently conducting are:

- CORE: Long-term Catheter (LTC): This QIA focuses on lowering the number of patients with a catheter greater than or equal to 90 days.
- Depression: This QIA focuses on supporting facility efforts to increase the proper administration and documentation of depression screenings.
- Home Referrals: This QIA focuses on increasing the number of in-center hemodialysis patients referred to self-care modality at home.
- Infection Detection: This QIA focuses on reducing the rate of bloodstream infections (BSIs).
- Transplantation: This QIA focuses on increasing the rate of patients on a transplant waitlist regardless of modality.

For more information on the Network's QIAs, please visit our [QIA page](#). You don't have to be a selected facility to utilize the resources and improve your facility outcomes. Please feel free to contact the [Quality Improvement Department](#) for more information or help implementing any of these resources.



END STAGE RENAL DISEASE NETWORK OF TEXAS

ESRD Facility Handbook Acknowledgement

Facility Name: _____

Facility Administrator/Clinic Manager: _____

I, as the Facility Administrator/Clinic Manager, acknowledge that I have downloaded and read the ESRD Facility Handbook and its appendices and understand the role of the Network and the requirements and responsibilities of my facility to the Network under state and federal regulations upon certification by CMS to provide dialysis services. I hereby ask ESRD Network of Texas, Inc. to finalize my facility's Network Agreement between my facility and ESRD Network 14.

Signature: _____

Date: _____



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