During our most recent Grievance Audit it was identified that there has been a large increase in the number of Involuntary Patient Discharges that occurred due to Nonpayment. While discharges for Nonpayment is an acceptable discharge reasons, under the conditions for coverage (CfC), both the Network and CMS are concerned with the recent increase in these discharges. The expectation is that facility staff is working closely with their patients to ensure patients continued medical healthcare coverage. Steps facilities can take are to involve financial counselors and/or social workers with resource acquisition processes such as (Medicaid Applications, Medicare Applications, and National Kidney Fund Applications). Educate patients on the importance and how critical it is that NKF funds received should only be used to pay their healthcare premiums.

The National Forum of ESRD Networks has released The Dialysis Patient Grievance Toolkit developed by the Kidney Patient Advisory Council (KPAC) to help patients as they work through the Grievance System, with a continued strong emphasis on the role of the Network in advocating for patients and families. While most facilities and all Networks have a Grievance Process, this is the first time that process has been explained through the patient’s eyes.

We are pleased to announce the Network has several new staff members who bring fresh depth and perspective to our team. EdNesha Smith, LMSW, joins our team in the role of patient services director, Ivana Harper BSW, is our new quality improvement coordinator, and Patricia Shaffer joins as our new quality improvement specialist. Be sure to check the staff roster in this edition, and please don’t hesitate to contact anyone—even just to introduce yourself or voice an opinion.

Thank you for all you do for our patients and families in Texas as we work together to ensure we are providing the best care possible. Always feel free to reach me via email at malbin@nw14.esrd.net or phone 469-916-3809.

Mary Albin
ESRD Network 14 Executive Director

Continued on page 2
In 2018, Network 14 continues to work with facilities that have high long-term catheter (LTC) rates based on CROWNWeb baseline data from June 2017. We looked at facilities in Texas with high bloodstream infections (BSI) and LTC rates of >15%. We found that 54 facilities met this criteria. It is important to mention that 23 of the facilities enrolled in the LTC project this year are rollover facilities from the 2017 LTC project. Many of these facilities met the 2% reduction goal in 2017 but still had rates that fell in the 15% or greater LTC rate range at baseline. The national goal for all facilities across the nation is to have LTC rates below 10%.

The 2018 LTC project launched in March 2018 and is named the Catheter Operation Reduction & Elimination (CORE) as a continuation from the previous year. The 54 focus facilities are in one pool and will be required to complete all interventions included in this quality improvement activity (QIA) this year, as opposed to last year where we had two subgroups of facilities based on their LTC rates. The Network goal is to decrease LTC rates by at least 2% overall by the end of September 2018. Interventions include an introduction webinar hosted by the Network on March 14, 2018, with the 54 focus facilities. Also, monthly review of project progress during QAPI/QA meetings is required for facilities to discuss barriers and develop plans of action. All facilities are required to complete monthly reports via Survey Monkey. A root cause analysis is to be completed at the beginning of the project to identify reasons why LTC rates are high in each clinic. Patient engagement is also required.

The top root causes as of May 2018 include: patient refusal to obtain a fistula or a graft, comorbidities, exhausted sites, appointment issues, referral issues, lack of communication, failure to initiate permanent access plan, payment/reimbursement issues, lack of available surgeons, internal process failures such as high staff turnover, and hospital discharge of patients with no access or no access plan in place.

Based on these findings, facilities will develop and implement interventions tailored to the needs of each clinic. Best practices learned in 2017 include: early referrals within the first week of admission, having a regional vascular access coordinator who meets with vascular access managers at the facility level every two weeks, and having nephrologists and surgeons.

Continued on page 3
collaborate with local hospitals to facilitate permanent access placement within the first 90 days.

Results from most recent data provided to the Networks from CROWNWeb are displayed in the chart below. Our baseline this year is 20.09% LTC rate and the goal is to decreased to an overall LTC rate of 17.09% or below. Based on preliminary results, the Network is optimistic that these rates will continue to trend down as facilities implement interventions.

The Network recognizes the strenuous work and efforts these facilities and patients are undergoing to make this project a success. Our ultimate goal is that patients, providers, and stakeholders continue to work together in finding solutions to decrease long-term catheter rates in their facilities.

“There are no secrets to success. It is the result of preparation, hard work, and learning from failure.”
Colin Powell.

For more information on this project visit our CORE LTC page [here](#).
The Bloodstream Infection (BSI) Quality Improvement Activity (QIA) is working with 50% of Network 14’s facilities with the highest bloodstream infection (BSI) rates this year, which is a total of 264 facilities. Facility selection was based on their National Healthcare Safety Network (NHSN) data submitted from January to June 2017. The average BSI rate of the QIA group was 1.25, compared to a Network wide average of 0.46. The goal of each facility in the QIA is to achieve a 20% or greater relative reduction in their pooled mean rate at re-measurement compared to their 2017 BSI rates. And as of April, the data shows 100% of the BSI QIA facilities are on target to meet their 20% RI goal.

The BSI QIA’s four main project components are:

- Coalition
- Focused Education
- Online resources

- Network Calendar
- Nationally Recognized Events
- Facility Plan

CDC Core Interventions

Patient Engagement

NHSN Monthly Audits

NCC HAI LAN & HIE

- Four monthly
- Annual Training

- Bi-monthly meetings
- Assist 20% Join
Continued from page 4

Patient engagement at all levels are emphasized in each of the monthly project activities. Facilities have the option to participate in nationally recognized events, promote their facility’s patient engagement plan, or utilize the Network’s patient created calendar of important health topics. The monthly topics are available as flyers in both English and Spanish and can be found on the Network’s website. In addition, the BSI QIA facilities are participating in bi-monthly national learning and action network calls to share best practices, learn how to reduce BSIs, and learn about proven methods for bloodstream infection prevention.

Successes reported by the QIA facilities include improved hand washing by patients without being asked, significant catheter reduction among their patients, and reduced missed treatments. Less antibiotic usage related to access issues and increased understanding by patients of how washing their access can help prevent infections have also been positive outcomes. Staff is becoming more active in holding each other accountable for following infection control measures, patients seem more willing to ask questions if they don’t know the facility’s policies, and many facilities are reporting zero BSIs for three months.

The BSI QIA facilities have also joined the Centers for Disease Control and Prevention’s Making Dialysis Safer for Patients Coalition this year and are working hard to engage more patients in their facilities to become facility patient representatives. The QIA facilities are also learning about the national Health Information Exchange (HIE), in addition to local regional HIEs, and how facilities can improve communications with other health providers to provide better and safer health care for their patients.

To learn more about the BSI QIA initiative, or if you would like more information on the resources used in this year’s BSI QIA, you can find them on our project page at www.esrdnetwork.org/infection-detection.
In 2018, Network 14 initiated work with facilities based on transplant wait list rates provided by UNOS combined with CROWNWeb patient data. Our baseline (12.44%) was obtained from October 2016 though June 2017 data. We looked at facilities in Texas with the greatest opportunity for improvement based on location (access to transplant centers) and UNOS wait list rates. We found that 185 facilities met this criteria, which accounted for about 30% of eligible total Network facilities. As mandated by the Center for Medicare & Medicaid Services (CMS), the goal for 2018 is to increase kidney transplant wait list rates by at least 10% by the end of September. Currently, the national wait list rate is 18.5% and CMS’ goal for all facilities across the nation is to reach a 30% kidney transplant wait list rate by 2023.

The 2018 LTC project launched in February 2018 and is named “Transplant Improvement Program for Success” (TIPS). Facilities were notified via email and contacted via phone as needed. All 185 focus facilities are in one pool and will be required to complete all interventions included in this quality improvement activity (QIA). Interventions within this project include an introduction webinar hosted by the Network on February 15, 2018, with all the focus facilities. Also, root cause analysis (RCA) is to be completed at the beginning of the project to identify reasons why transplant wait list rates may be low in each clinic. Monthly review of project progress during QAPI/QA meetings is required. All facilities are required to track and report the 7 steps leading to transplant. Patient engagement is also required as well as participation in national transplant learning and action network (LAN) calls every other month.

The top root causes as of May 2018 include perception that the patient is not a good candidate, time constraints to provide adequate transplant advice, lack of staff and patient/family training regarding transplant, obesity, lack of follow up with appointments, eligibility, lack of motivation and family support, ineffective systemic teaching practices, no protocol or standard process in place regarding follow up and/or revisiting transplant options with existing patients, distance to transplant centers, lack of communication, and national shortage of organs/donors.

Continued on page 7
Based on these findings, facilities will develop and implement interventions tailored to the needs of each patient and clinic. Best practices learned so far in 2018 show that early assessment and continuous education can lead to more patients being listed for transplant; having a relationship with transplant coordinators allows for better flow of key information between providers; and ensuring facility staff, patients, nephrologists, and transplant surgeons are working as a team.

The 7 steps leading to transplant include: 1. Patient suitability for transplant, 2. Patient interest in transplant, 3. Referral call to transplant center, 4. First visit to transplant center, 5. Transplant center work-up, 6. Successful transplant candidate, and 5. On waiting list or evaluate potential living donor. The following graph shows the progress of the 7 steps based on most recent data from February 2018.

The Network is deeply thankful for the diligent work these facilities and patients have set forth in order to achieve this goal in 2018. So far, as demonstrated through the project, successful collaboration between patients, facilities, and providers will continue to improve kidney transplant wait list rates for our dialysis population in Texas.

For more information on this project please visit our transplant improvement section [here](#).
In 2018, Network 14 began work with facilities based on CROWNWeb patient data for depression screenings. Our baseline (12.44%) was obtained from October 2016 though June 2017 data. We looked at facilities in Texas with the greatest opportunity for improvement based on the answer choices selected for patients in CROWNWeb. While entering responses for depression screenings is a reporting requirement, we are aiming to decrease responses to options 3 and 6 for this project. The list of options are:

- **Option 1.** Screening for clinical depression is documented as being positive (and a follow-up plan is documented).
- **Option 2.** Screening for clinical depression documented as positive, a follow-up plan is not documented, and the facility possesses documentation that the patient is not eligible.
- **Option 3.** Screening for clinical depression documented as positive, the facility possesses no documentation of a follow-up plan, and no reason is given.
- **Option 4.** Screening for clinical depression documented as negative and no follow-up plan required.
- **Option 5.** Screening for clinical depression not documented, but the facility possesses documentation stating the patient is not eligible.
- **Option 6.** Clinical depression screening not documented and no reason is given.

The goal is to decrease responses to Option 3, “Screening for clinical depression documented as positive, the facility possesses no documentation of a follow-up plan, and no reason is given”, by 10%. The Network must also decrease the response to Option 6, “Clinical depression screening not documented, and no reason is given”, to zero (0). With this in mind, we first began by excluding facilities who had a combined rate of 0% for options 3 and 6. Then, we took the facilities who had selected option 6 for less than 20% of their patients. In other words, we selected facilities who had screened 20% or less, of patients. From there, we took the top 10% with the highest rates for option 3. We found that 69 facilities met all criteria, which accounted for about 10% of eligible total Network facilities.
Continued from page 8

The 2018 Depression Screening project launched in January 2018 and will run through September 2018. Facilities were notified via a notification template that detailed project selection and objectives. The 69 focus facilities will be required to complete all interventions included in this quality improvement activity (QIA). Interventions within this project include the root cause analysis (RCA), inclusion of a facility patient representative (FPR), plan do study act (PDSA) cycles, data validation and accuracy, participation on the National Coordinating Center Learning and Action Network (NCC LAN), and sustainability. Each phase, or intervention set, also includes a webinar hosted by the Network. Monthly review of project progress during QAPI/QA meetings is required. All facilities are required to track and report their depression screenings monthly to the Network. The Network then compares these rates to the CROWNWeb data and reports it back to the facilities.

The top root causes for either inaccurate depression screening reporting or lack of depression screenings are: staff turnover and low staffing resulting in screenings not being completed or entered into the system on time, patient’s unwillingness to be open and honest during the screenings, the patient’s ability to stay before or after treatment for follow up discussions, and planning and/or lack of training on the depression screening process.
In 2018, Network 14 initiated work with facilities based on home training rates provided by the National Coordinating Center (NCC) via CROWNWeb patient data. Our baseline (0.56%) was obtained from October 2016 though June 2017 data. We looked at facilities in Texas with the greatest opportunity for improvement based on location (access to home training center) and home training rates. We found that 181 facilities met this criteria, which accounted for about 30% of eligible total Network facilities. The Network also included eight home-only facilities to participate in the Home QIA project as a resource, best demonstrated practices as well as a referral source for in center facilities. As mandated by the Center for Medicare & Medicaid Services (CMS), the goal for 2018 is to increase the number of patients doing home training by at least 10% by the end of September. Currently, 12% of ESRD patient dialyze at home and CMS’ goal for the nation is to reach a 16% by 2023.

The 2018 Home QIA project launched in January. Facilities were notified via email and contacted via phone as needed. The 189 focus facilities will be required to complete all interventions included in this quality improvement activity (QIA). The first intervention assigned to the facilities was a root cause analysis (RCA), to be completed at the beginning of the project to identify reasons why home training rates may be low in each clinic. The top root causes identified by the facilities include: perception that the patient is not a good candidate, lack of communication between home referral program center and facility, time constraints to provide adequate home modality education, lack of motivation and family support, and lack of communication. Facilities will work through the root causes using resources they develop, patient feedback, and any other outside best practices and resources shared by the Network. Facilities are also required to participate in the national home learning and action network (LAN) calls every other month.

Continued on page 11
Continued from page 10

Based on these findings, facilities are to develop and implement interventions tailored to the needs of each patient and clinic. Best practices learned so far in 2018 show that early assessment and continuous education can lead to more patients choosing a home modality and having a relationship with patient champions and professional on a home modality.

The 7 steps leading to home training include: 1) Patient interest in home dialysis, 2) Educational session to determine the patient’s preference of home modality, 3) Patient suitability for home modality determined by a nephrologist with expertise in home dialysis therapy, 4) Assessment for appropriate access placement, 5) Placement of appropriate access, 6) Patient accepted for home modality training, 7) Patient begins home modality training. The following graph shows the progress of the 7 steps based on most recent data from March 2018.
The ESRD Networks and CMS have joined efforts to address and promote patient engagement through a variety of strategies.

- Promoting patient and family engagement at the facility level
- Establishing a Patient Engagement Learning and Action Network (PE LAN)
- Involving more patients and family members in Network boards and committees
- Looking to our patients as Subject Matter Experts (SMEs)

We know that the Network can only succeed in collaboration and partnership with the renal community, including our patients, and we extend our hand to be “all in” as we embark on this new journey. Facilities are encouraged to have one to three facility patient representatives (FPRs) to engage patients in being proactive in their health care. FPRs also serve as a vessel for facility staff and patients in relaying important facility information and patient involvement activities. Patients need support from both the facility and the Network, and to ensure no one is without support, the Network is advocating all facilities to have a peer-to-peer support group.

**Developing Patient- And Family-Centered Peer Support Programs**

**Strategies for Developing Peer Support Programs**

- Build a team. Invite patients, families, physicians, nurses, clinical staff, and family members to create the vision.
- Connect program to strategic goal(s) to advance patient- and family-centered care
- Share research and testimonies on the efficacy of peer support, creating a positive image.
- Chose a delivery mode, and design your program building on evidence-based practices.

*Continued on page 13*
Peer-Led Support Groups

- Key Decisions:
  - Define the purpose of the group
  - Identify long- and short-term goals
  - Decide on a forum (educational, support/projects, formal/informal, open/closed)
  - Develop guidelines and ground rules (confidentiality, membership, conflict resolution, group feedback)
  - Determine what supportive resources are available (financial, educational, transportation)

- Necessary Components:
  - Dedicated staff member(s) and/or patient leader(s) to facilitate, prepare agenda and materials, and invite participants.
  - Training and ongoing mentoring opportunities for peer leaders
  - Scheduled opportunities for peer leaders and staff to discuss experiences and concerns.
  - One-to-one model of peer support
    - Support is intentional, personalized, available as needed, and is relationship-based

Motivational Interviewing Methods

Open-Ended Questions - encourages patients to do most of the talking, while staff listens and responds with a reflection or summary statement. The goal is to promote further dialogue that can be reflected back to the patient by the staff. Open-ended questions allow patients to tell their stories and have a richer, deeper conversation that flows and builds empathy.

Continued on page 14
Continued from page 13

Example: “What’s happened since we last met?”

Reflective Listening - involves listening carefully to patients and then making a reasonable guess about what they are saying.

Example: “It sounds like you recently became concerned about your [problem/ behavior].”

Exploring Importance and Confidence - provides staff with information on how patients view the importance of changing and the extent to which they feel change is possible. It also can be used to get patients to give voice to what they would need to do to change.

Example: “How would your life be different if you moved from [#] to [#]?”

Patient Advisory Committee

The ESRD Network of Texas, Inc. (ESRD Network 14) Patient Advisory Committee (PAC) has continued to grow and added 11 new Patient Subject Matter Experts (PSMEs) to its committee. PAC members are currently working on Quality Improvement Activities and a Network dialysis resource kit for newly diagnosed patients. The PAC elected to name the kit H.O.P.E also known as “Help on Processing Everything” Dialysis Resource Kit. These resources will encompass our PAC’s personal story and other resources they found helpful when diagnosed with chronic kidney disease. ESRD is impacting people in the state of Texas and the Network is aiming to provide resources to support patients, family members, and caregivers in adjusting their lifestyle. Network 14 will continue to provide information for lifelong sustainability.

- PAC members provide a voice as part of a larger whole; the entire ESRD patient population in the state of Texas.
- PAC members work with the Network to improve the quality of care and quality of life for Texas ESRD patients. Some PAC members also serve on the Medical Review Board and the Board of Directors.
- Share ideas to help improve patient-centered care and communication. In addition, they provide a patient perspective by reviewing patient education materials to ensure they are helpful for patients.

Patient, Family and Caregiver Engagement (continued)

Summer 2018
On April 28, 2018, the NHSN team deployed NHSN v8.9 into production. There have been several updates and changes with this release, including an analysis updates within the Patient Safety, Dialysis, Long Term Care and Bio Vigilance components. The full release notes with details about the changes for NHSN v8.9 can be found here on the CDC’s website. The Dialysis Component has several changes and are shown below.

### Changes to the Dialysis Component

<table>
<thead>
<tr>
<th>Dialysis Summary</th>
<th>(1773) A new calculator has been created to help users determine the first two working days of the month when reporting Denominators for Dialysis Event Surveillance. The calculator is available on the Dialysis Event homepage under the ‘Calculators’ tab: <a href="https://www.cdc.gov/nhsn/dialysis/event/index.html">https://www.cdc.gov/nhsn/dialysis/event/index.html</a>.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analysis and Reporting</td>
<td>(1726) To obtain accurate rates, p-values, and incidence density percentiles, the dialysis rate tables and run charts have been updated with 2016 aggregate data. (1977/2007) The existing ‘TAP Report – Bloodstream Infection (BSI) Data has been renamed to ‘Excess Infections – Bloodstream (BSI) Data’ and updated to allow group users to view the number of excess infections grouped by summary year (summaryYr), summary quarter (summaryYQ), and summary half year (summaryYH).</td>
</tr>
</tbody>
</table>

The Working Days Calculator can also be found at [https://nhsn.cdc.gov/DialysisCalculator/](https://nhsn.cdc.gov/DialysisCalculator/).

The new Excess Infections Report can be located under Analysis > Reports within NHSN.

NOTE: Users who wish to use any of the new analysis output options must regenerate datasets.

Please send all questions related to the updates to the NHSN Helpdesk at NHSN@cdc.gov.

### CMS QIP NHSN Calendar Year 2018 Reporting Requirements for Dialysis Event Data:

- Q1 2018 data due 06/30/2018 (Q1 = January 2018 - March 2018)
- Q2 2018 data due 09/30/2018 (Q2 = April 2018 - June 2018)
- Q3 2018 data due 12/31/2018 (Q3 = July 2018 - September 2018)
- Q4 2018 data due 03/31/2018 (Q4 = October 2018 - December 2018)
The In-center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey collects data from patients about the hemodialysis care they receive from in-center hemodialysis (ICH) facilities. Survey results are used by consumers (to help inform their choice of a hemodialysis center), by ICH facilities in their quality initiatives, and by the Centers for Medicare & Medicaid Services (CMS), to monitor the quality of care provided to patients with end-stage renal disease. The national survey is conducted with samples of hemodialysis patients 18 and older who receive outpatient hemodialysis for 3 months or longer at their ICH facility.

The 2016 ICH CAHPS Fall Survey and the 2017 ICH CAHPS Spring Survey combined results were recently posted on Dialysis Facility Compare on the www.medicare.gov website in April 2018. There are three ICH CAHPS composite measures and three global ratings, which are based on the two combined survey periods, and shown below with the average response rates for Texas versus the national average. Texas rated slightly higher than the national average in two areas, the Rating of the Nephrologist (which comes from Question 8 of the survey) and the Nephrologists’ Communication and Caring score (which is a composite of Questions 3, 4, 5, 6, 7, and 9 from the survey).

The ICH CAHPS Survey can be found here along with the Administration and Specifications Manual.
ESRD Network of Texas, Inc.
Medical Review Board Recommendations

**Goals for Clinical and Safety Performance Measures/Quality Indicators**

Calendar Year 2018/Payment Year 2020

ESRD Network of Texas endorses CMS Quality Incentive Program goals in lieu of setting additional Network-specific goals.

*Denotes new measure for Calendar Year 2018

<table>
<thead>
<tr>
<th>Clinical Performance Measures</th>
<th>Goals</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kt/V Dialysis Adequacy (comprehensive) *</td>
<td>98.56%</td>
<td>PY2020 QIP Benchmark</td>
</tr>
<tr>
<td>Hypercalcemia*</td>
<td>0.00%</td>
<td>PY2020 QIP Benchmark</td>
</tr>
<tr>
<td>Vascular Access – Arteriovenous Fistula (AVF)</td>
<td>79.90%</td>
<td>PY2020 QIP Benchmark</td>
</tr>
<tr>
<td>Vascular Access – Catheter ≥ 90 days*</td>
<td>3.11%</td>
<td>PY2020 QIP Benchmark</td>
</tr>
<tr>
<td>Standardized Readmission Ratio (SRR)*</td>
<td>0.629</td>
<td>PY2020 QIP Benchmark</td>
</tr>
<tr>
<td>Standardized Transfusion Ratio (STrR)*</td>
<td>0.429</td>
<td>PY2020 QIP Benchmark</td>
</tr>
<tr>
<td>Standardized Hospitalization Ratio (SHR)**</td>
<td>0.670</td>
<td>PY2020 QIP Benchmark</td>
</tr>
<tr>
<td>NHSN Bloodstream Infection (BSI)*</td>
<td>0.00</td>
<td>PY2020 QIP Benchmark</td>
</tr>
<tr>
<td>ICH CAHPS – Nephrologists’ Communication and Caring</td>
<td>78.09%</td>
<td>PY2020 QIP Benchmark</td>
</tr>
<tr>
<td>ICH CAHPS – Quality of Dialysis Center Care and Operations</td>
<td>71.52%</td>
<td>PY2020 QIP Benchmark</td>
</tr>
<tr>
<td>ICH CAHPS – Providing Information to Patients</td>
<td>86.83%</td>
<td>PY2020 QIP Benchmark</td>
</tr>
<tr>
<td>ICH CAHPS – Overall Rating of Nephrologists</td>
<td>76.57%</td>
<td>PY2020 QIP Benchmark</td>
</tr>
<tr>
<td>ICH CAHPS – Overall Rating of Dialysis Center Staff</td>
<td>77.42%</td>
<td>PY2020 QIP Benchmark</td>
</tr>
<tr>
<td>ICH CAHPS – Overall Rating of the Dialysis Facility</td>
<td>82.48%</td>
<td>PY2020 QIP Benchmark</td>
</tr>
<tr>
<td>Mortality, Hospitalization, Transplant</td>
<td>Facility is “As Expected” or “Better than Expected”</td>
<td>Dialysis Facility Report</td>
</tr>
</tbody>
</table>

*On these measures, a lower rate indicates better performance
QIP Benchmark: 90th percentile of performance rates nationally during CY 2016
Below are the upcoming facility data deadlines for CROWNWeb, the National Healthcare Safety Network (NHSN), ICH CAHPS, and Dialysis Facility Compare.

### Calendar Year 2018 QIP Calendar

<table>
<thead>
<tr>
<th>June</th>
</tr>
</thead>
</table>
| **CROWNWeb Assistance:** Sáde Castro  
Information Systems Coordinator  
scastro@nw14.esrd.net  
Direct: 469-916-3805  
Main: 972-503-3215 x 7805  
Fax: 972-503-3219  |
| **QIP Assistance:** Lydia Omogah  
Senior Project Analyst  
omogah@nw14.esrd.net  
Direct: 469-916-3802  
Main: 972-503-3215 x 7802  
Fax: 972-503-3219  |
| • CROWNWeb April Clinical closure (6/30)  
• ICH CAHPS 2018 Spring Survey Data Collection Period (4/20-7/13)  
• NHSN 2018 Q1 data due (6/30) |

<table>
<thead>
<tr>
<th>July</th>
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| • CROWNWeb May Clinical closure (7/31)  
• DFC website updated with DFC measures from QDFC-Preview for July 2018 report (7/25)  
• FY 2019 DFR reports available (7/15)  
• ICH CAHPS 2018 Spring Survey Data Collection Period (4/20-7/13)  
• ICH CAHPS 2018 Spring Survey Data Submission Deadline (7/25)  
• FY 2019 Preview PSR (submit formal inquiries or clarification questions)  
• QDFC-Preview for October 2018 reports available and comment period begins (7/15) |

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<thead>
<tr>
<th>August</th>
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</table>
| • CROWNWeb June Clinical closure (8/31)  
• Pain Assessment Screening Deadline (8/31)  
• FY 2019 Preview PSR (submit formal inquiries or clarification questions) closes  
• QDFC-Preview for October 2018 comment period closes (8/15) |

<table>
<thead>
<tr>
<th>September</th>
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</table>
| • CROWNWeb July Clinical closure (9/30)  
• NHSN 2018 Q2 data due (9/30) |

<table>
<thead>
<tr>
<th>October</th>
</tr>
</thead>
</table>
| • CROWNWeb August Clinical closure (10/31)  
• DFC website updated with DFC measures from QDFC-Preview for October 2018 report (10/24)  
• ICH CAHPS 2018 Fall Survey Data Collection Period (10/19-11/1) |

<table>
<thead>
<tr>
<th>November</th>
</tr>
</thead>
</table>
| • CROWNWeb September Clinical closure (11/30)  
• ICH CAHPS 2018 Fall Survey Data Collection Period (10/19-11/11)  
• QDFC-Preview for January 2019 reports available and comment period opens (11/1)  
• QDFC-Preview for January 2019 comment period closes (11/15) |

<table>
<thead>
<tr>
<th>December</th>
</tr>
</thead>
</table>
| • CROWNWeb October Clinical closure (12/31)  
• ICH CAHPS 2018 Fall Survey Data Collection Period (10/19-11/1)  
• NHSN 2018 Q3 data due (12/31)  
• Post PSC FY 2019 in English and Spanish  
• PY 2019 scores and payment reductions published |
Grievances Quality Improvement Efforts and Initiatives

The ESRD Network of Texas (Network 14) Patient Services Department is continually working to improve the patient experience of care, facilitate positive provider interactions, and reduce grievances. Although patients provide the initial notification of a grievance, the Network contacts providers to offer resolution guidance and technical assistance related to reported grievances. In completing our most recent focused audit of patient grievances, the most prevalent areas of concern were related to:

- Clinical quality of care
- Staff-related issues
- Treatment-related issues

Many of the most prevalent areas of concern were linked to following secondary areas of concerns:

- Patient health and safety questions
- Professionalism of facility staff members
- Scheduled treatment times

In many cases, patient grievances were resolved by the facility staff, utilizing a patient-centered approach, mediation, and effective communication between patients and facility staff. The Network encourages continued use of related interventions and use of internal facility grievance processes to improve patient experience of care.

Professional Tools and Resources

Missing Patients Protocol

The ESRD Network of Texas (Network 14) Patient Services Department is frequently contacted by facility staff with concerns related to patients missing treatment for thirty or more

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consecutive days. According to the National Kidney Fund’s Adherence Survey, more than 18% of patients reported that they skipped dialysis treatments altogether.

In an effort to both, advocate for patient’s rights and assist facilities in maintaining their standing with CMS, Network 14 has developed a Missing Patients Protocol to assist with handling patients who miss thirty or more consecutive days of treatment, in accordance with the Conditions for Coverage (CfCs). This resource is posted on the Network’s website: http://www.esrdnetwork.org/sites/default/files/Missing%20Patients%20Protocol.pdf.

Lost to Follow Up and Withdrawal from Care

Patients miss treatments for various reasons. In some cases, facilities exhaust all efforts to contact patients and are unsuccessful. These patients are Lost to Follow-up. To assist facilities in addressing such concerns, the Network has developed a lost to follow-up guidance letter for patients whose whereabouts are unknown and all attempts to contact the patients have failed. This resource is posted on the Network’s website at http://www.esrdnetwork.org/social-worker-tools-resources.

Involuntary Discharges

Facility staff members often contact the Network with questions and concerns related to Involuntary Discharges. To provide direction to dialysis facility professionals on how to complete involuntary discharge (IVD) paperwork, the Network developed an IVD Process Webinar. This resource is posted on the Network’s website at http://www.esrdnetwork.org/sites/default/files/IVD%20webinar-8%2024.pdf.

Additional IVD resources related to the process, conditions for coverage, the DSHS Incident Form, and CROWNWeb’s admit discharge reasons are also posted on the Network’s website: http://www.esrdnetwork.org/social-worker-tools-resources.

We appreciate all you do for patients and families. Please feel free to contact the Patient Services Department with any questions or concerns.
## ESRD Network 14 Staff Contacts

Do NOT Email Patient-specific Information. Fax Only.

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### Join us on Twitter

ESRD of Texas Network 14 at: www.esrdnetwork.org

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