

C.3.23.B. Provide Technical Assistance to Facilities to Promote Timely and Accurate Data Submission to CROWNWeb, NHSN, and Other CMS-Designated Data Systems

CMS relies on the data in CROWNWeb, NHSN and other data systems to establish performance on the ESRD QIP and other quality improvement initiatives. To ensure fair facility payment and appropriate stewardship of quality improvement resources, these data systems must contain the most complete and accurate data possible. The Network can help CMS achieve this goal by providing technical assistance to facilities in several areas. The Network shall monitor vascular access reporting and if less than 95% of facilities in any given month are not reporting at least 95% of vascular access data for all eligible patients, the Network shall identify barriers to achieving this goal, and potential interventions to improve the reporting rate, on the COR Monthly Report. The Network shall provide individualized assistance to identify and resolve the root causes in facilities that are reporting vascular access data for less than 90% of their eligible patients. The Network shall report vascular access data on a monthly basis using the COR Monthly Report.

The Network shall follow all instructions and guidance as provided in Attachment J-12, CROWNWeb Data Management Guidelines. All deliverables are described in Chapter 3 of this Attachment, and will be provided by the Network as instructed in this document.

The Network shall validate that all facilities have successfully completed and submitted 2744A forms by the first Friday in May of each contract year. The Network shall report successful completion of the ESRD Facility Surveys by providing a signed confirmation to the COR electronically by the second Friday in May.

The Network shall provide monthly updates of CROWNWeb activities, as directed in Chapter 3 of the CROWNWeb Data Management Guidelines, on the COR Monthly Report, and meet compliance of CROWNWeb metrics as directed by this document.

The Network shall assist new and previously nonparticipating facilities with NHSN enrollment if requested by facilities. Additionally, the Network shall provide assistance to facilities to improve facility processes related to the submission of data to NHSN, and resolve any identified issues with COR assistance related to the individual patient / facility.

C.4. Quality Improvement Activities (QIAs)

The Network shall incorporate a focus on disparities in conducting all of the activities outlined in this SOW. In each QIA, the Network shall analyze data and implement interventions aimed at reducing disparities. All QIAs shall use innovative approaches and rapid cycle improvement that incorporate boundariliness, unconditional teamwork, are customer-focused and sustainable to achieve the strategic goals of the ESRD Network Program. The Network shall use data provided by the ESRD NCC or NHSN for each QIA as described. The Network shall not change the data provided by the ESRD NCC in any manner or the data derived from NHSN as prescribed by CDC. The Network shall consult with the ESRD NCC or CDC if there are questions regarding the data. The Network shall evaluate the success of the interventions described in the QIA plan. It is expected that the QIA plan will be a living document and change throughout the QIA using Plan-Do-Study-Act cycles as established in the initial plan. The Network shall report barriers to interventions and revisions each month on the COR monthly calls.

C.4.1. Patient Safety: Healthcare-Associated Infections

Infections are the second leading cause of death in patients with end-stage renal disease (ESRD). The antecedent for the majority of these infections is catheter-related bloodstream infection (CRBSI)³. As a result, the following AIM with a 5-year target has been set to guide national health promotion and management to improve the health of all people in the United States living with ESRD: *by 2023, reduce the national rate of blood stream infections in dialysis patients by 50% of the blood stream infections that occurred in 2016.* The Networks shall reduce the rate of blood stream infections by supporting NHSN, participating in the ESRD NCC HAI LAN, and assisting dialysis facilities in the implementation of the CDC Core Interventions.

C.4.1.A. Support NHSN

The Network shall comply with all requirements specified in Attachment J-9, HAI and Patient Safety, with respect to supporting NHSN to reduce rates of dialysis events.

The Network shall perform the following to support NHSN data quality:

- Assist new and returning facilities in the Network service area to successfully enroll in NHSN.
- Support facilities in reporting dialysis event data for 12 months, and support facilities in reporting data to any or all other modules in NHSN in support of ESRD QIP requirements, or as necessary for HAI prevention efforts.
- Establish the Network as group administrator for the NHSN database system for the dialysis facilities in the Network's service area.
- Assist facilities in ensuring that data are entered into the NHSN database accurately and in a timely manner.
- Support facilities in completing annual NHSN Dialysis Event Surveillance training (<https://www.cdc.gov/nhsn/dialysis/event/index.html>). By the end of the third quarter each contract year, the Network shall achieve 90% or more of facilities completing the online annual NHSN Dialysis Event Surveillance training during that contract year. The Network shall report the percent of facilities completing training during that contract year on the monthly COR report.
- Perform quarterly NHSN data checks using a CDC-created and CMS-approved data checklist. The Network shall follow up with facilities to correct data errors. March data checks shall review 4th quarter of the previous calendar year. June data checks shall review 1st quarter data. September data checks shall review 2nd quarter data. December data checks shall review 3rd quarter data. These quarterly data checks are designed to help facilities meet ESRD QIP requirements. The Network shall report the results of the data checks on the COR Monthly Report for the month after the data checks occur.
- Assist at least 20% of the BSI QIA cohort to join a Health Information Exchange (HIE) or another evidence-based highly effective information transfer system as approved by the COR and SME to receive information relevant to positive blood cultures during transition of care.

³ Soi V, Moore CL, Kumbar L, and YeeIn J, Prevention of Catheter-related Bloodstream Infections in Patients on Hemodialysis: Challenges and Management Strategies; Int J Nephrol Renovasc Dis. 2016; 9: 95–103

C.4.1.B. Participate in the ESRD NCC HAI LAN

The ESRD NCC HAI LAN has two primary purposes. The first is to improve information communication across care settings, with emphasis on communication between hospitals and dialysis centers caring for the same ESRD patients. The second is to increase awareness of and implementation of CDC Core interventions.

The Network shall perform the following to support ESRD NCC HAI LAN:

- Invite all facilities within the Network service area to participate.
- Invite QIN-QIO(s), HIINs, state/local health departments, State Survey Agencies, long-term care facilities, hospitals, dialysis facilities including regional leadership, and patient representatives to support communication and BSI QIA. At a minimum the Network shall ensure there is a participating cohort formed by all facilities participating in the BSI QIA, a minimum of two (2) hospitals from each state in the Network service area, and two (2) patients, family members and/or caregivers from each state in the Network service area.
- Ask dialysis organizations to identify facilities within the Network service area that have successfully implemented all of the CDC Core Interventions and have had no infections reported in NHSN for a minimum of six (6) months for inclusion in the LAN.
- Provide a list of participants for the NCC HAI LAN by December 31st of option year 2.
- Provide an updated list of participants for the NCC HAI LAN by October 31st of option year 2 for option year 3.
- Provide an updated list of participants for the NCC HAI LAN by October 31st for each subsequent option year.
- Attend the ESRD NCC HAI LAN every other month.
- Share identified interventions to improve the BSI rates from each LAN meeting with all facilities in the Network service area and report on the implementation of the interventions at QIA facilities in the monthly COR report.
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C.4.1.C. Reduce Rates of BSIs

The Network shall work through facilities to reduce BSI rates in outpatient dialysis facilities by:

- Revise the BSI QIA J-7 Short Form based on information identified in the rapid cycle improvement efforts of Option Year 1 by December 31st of option year 2
 - Include a plan to assist facilities to implement and monitor all of the CDC recommended interventions for dialysis BSI prevention (<http://www.cdc.gov/dialysis/prevention-tools/core-interventions.html>)
 - Describe in detail how the Network will educate the facility on the CDC Core Interventions, how the Network will assist the facility to implement the CDC Core Interventions, how the Network will assist the facility to monitor their own progress toward implementing the CDC Core Interventions and reduction of BSIs, and how the Network will monitor the progress of QIA facilities and assist the facilities that are unable to progress to goal.
 - Describe how Patient SMEs and/or family members or caregivers will be

involved at the facility level in discussion about infection control practices and ways to feel more comfortable bring issues to the attention of staff members.

- Revise the BSI QIA J-7 Short Form to include any changes the Network identified through rapid cycle improvement to improve the project plan for the subsequent option years by October 31st.
- Select at least 50% of facilities in the Network's service area including those facilities reporting the highest BSI rates.
- Provide the facilities in the BSI QIA with guidance to implement all CDC recommended interventions for dialysis BSI prevention (Surveillance and feedback using NHSN, hand hygiene observations, catheter/vascular access care observations, staff education and competency, patient engagement/education, catheter reduction, chlorhexidine for skin asepsis, catheter hub disinfection, and antimicrobial ointment) that the facility has not adopted or is having difficulty successfully implementing. The Network shall stress to facilities the Core Interventions identified by CDC as having the greatest potential to reduce the infection rate, catheter reduction and catheter interventions (scrub the hub, chlorhexidine for skin asepsis, antimicrobial ointment at the catheter exit site, staff education regarding the interventions with competency test, and regular audits to reinforce appropriate catheter care).
- Incorporate action steps developed from each ESRD NCC HAI LAN to assist facilities in implementing the COR interventions.
- Identify the number of facilities that have successfully implemented each of the CDC Core Interventions into facility practice and report this monthly in the DIF. The Network may ask the facilities about the use of interventions but should ask for enough documentation to ensure the facilities have successful implementation of the Core Interventions.
- Encourage the dialysis facilities to discuss the use of the CDC Core Interventions at QAPI meetings, in addition to infection rates, with the Medical Director for the facility.
- Assist facilities to complete a root cause analysis if there was successful implementation of all the CDC Core Interventions and the BSI rate did not decrease by at least 10% during the QIA.
- Use NCC provided data to identify facilities with a long-term catheter (LTC) (catheter in use \geq 90 days) in use rate above 15% (from the 50% of facilities in the Network's service area reporting the highest BSI rates). The Network shall report the LTC rate on the DIF monthly, as part of the Core Interventions, with the expectation that this rate will decrease by at least 2 percentage points by evaluation based on data available in October. June of the previous contract year shall be used as baseline.
- Demonstrate a 20% or greater relative reduction in the semi-annual pooled mean in the cohort with the highest 20% of BSIs in the Network service area at re-measurement compared to the previous year.
- Report the monthly quarterly pooled-mean rates for monitoring purposes only. Base year evaluation shall be based on the semi-annual pooled mean rates, which will consist of the combined first- and second-quarter data of 2015 as the baseline, and re-measurement shall occur from the combined first- and second-quarter data of 2016, and then again from the first- and second-quarter data for each subsequent option year of the contract. Beginning in option year 2, the Network shall report the semi-annual pooled mean rate for facilities from the third- and fourth- quarter of 2017 and then third- and fourth-quarter

data in the same manner for each subsequent option year as an additional data point. The Network shall create a custom report in NHSN for the QIA facilities as described by CDC to monitor and report the BSI rate on facilities in the QIA cohorts that have the highest 20% of BSIs in the Network service area.

- Report activities related to this QIA monthly in the COR Monthly Report.
- Provide the ESRD NCC with the names of BSI QIA facilities that continue or new facilities for the next option year by December 31st for option year 2 and by October 31st for subsequent option years. A facility may be removed and replaced for the next option year in the QIA if it is no longer in the cohort of facilities with the highest 20% of BSIs in the Network service area or maintains a BSI rate of zero for at least six (6) months of the QIA.
- Use CDC technical assistance and tools in enrolling facilities in NHSN and encouraging accurate reporting of data
- Share best practices in the area of reducing HAIs, BSIs, and sepsis (i.e., promoting evidence-based practices for BSI prevention in dialysis facilities and best practices for implementation)
- Involve patient SMEs and direct interventions at the targeted facilities to allow patients the ability to impact the care received at the facilities.
- Notify the regional corporate representative for each facility of the facilities selection for participation in the QIA and encouraged to participate with the Network to the extent desired.
- Encourage facilities to participate in CDC HAI training activities by encouraging all clinical staff to complete the CDC Infection Prevention in Dialysis Settings Continuing Education course at <http://www.cdc.gov/dialysis/clinican/CE/infection-prevent-outpatient-hemo.html>, as well as view the CDC video “Preventing Bloodstream Infections in Outpatient Hemodialysis Patients: Best Practices for Dialysis Staff” at <http://www.cdc.gov/dialysis/prevention-tools/training-video.html>.

CMS recommends that the Network learn about the National Action Plan to Prevent Healthcare-Associated Infections: Roadmap to Elimination (<http://www.hhs.gov/ash/initiatives/hai/esrd.html>).

Prevention of intravascular infections, blood-borne pathogen transmission (e.g., hepatitis B), and influenza and pneumococcal disease are priorities identified in the *National Action Plan to Prevent Healthcare-Associated Infections: Roadmap to Elimination* (see <http://www.hhs.gov/ash/initiatives/hai/esrd.html>).

C.4.2. Improve Transplant Coordination

The benefits of transplantation extend to ESRD patients regardless of age, gender, or ethnicity, as well as those with common comorbid conditions, including diabetes and hypertension⁴. As a result, the following AIM with a 5-year target has been set to guide national health promotion and management to improve the health of all people in the United States living with ESRD: *by 2023 increase the percentage of ESRD patients on the transplant waitlist to 30% from the 2016*

⁴ Merion RM, Ashby VB, Wolfe RA, et al. Deceased-donor characteristics and the survival benefit of kidney transplantation. JAMA 2005;294:2726-33

national average of 18.5%. The intent of the Transplant Coordination QIA is to promote early referral to transplant, and assist patients and providers to improve referral patterns by addressing barriers identified as the patient moves through the steps identified by Sullivan et al⁵. The Networks shall increase the number of patients on a transplant waitlist by participating in the ESRD NCC Transplant LAN, and assisting dialysis facilities in the implementation of interventions to support patients through the process of being placed on a waitlist.

C.4.2.A. Participate in the ESRD NCC Transplant LAN

The ESRD NCC Transplant LAN has two primary purposes. The first is to improve information communication across care settings, with emphasis on communication between transplant centers and dialysis centers caring for the same ESRD patients. The second is to increase awareness of and ways to support the patient through the waitlist process.

The Network shall perform the following to support ESRD NCC Transplant LAN:

- Invite all facilities within the Network service area to participate.
- Invite QIN-QIO(s), HIINs, State Survey Agencies, hospitals, transplant centers, dialysis facilities including regional leadership, and patient representatives to support communication and Transplant QIA. At a minimum the Network shall ensure there is a participating cohort formed by all facilities participating in the Transplant QIA, a minimum of two (2) transplant centers from each state in the Network service area or all transplant centers in the state if less than two (2), and two (2) patients, family members and/or caregivers from each state in the Network service area.
- Ask dialysis organizations to identify facilities within the Network service area that have successfully implemented process to support patients through the transplant waitlist process.
- Provide a list of participants for the NCC Transplant LAN by December 31st of option year 2.
- Provide an updated list of participants for the NCC Transplant LAN by October 31st of option year 2 for option year 3.
- Provide an updated list of participants for the NCC Transplant LAN by October 31st for each subsequent option year.
- Attend the ESRD NCC Transplant LAN every other month.
- Share identified interventions to improve the Transplant waitlist rates from each LAN meeting with all facilities in the Network service area and report on the implementation of the interventions at QIA facilities in the monthly COR report.

C.4.2.B. Increase Rates of Patients on a Transplant Waitlist

The Network shall work through facilities to increase rates of Patients on a transplant waitlist in outpatient dialysis facilities by:

⁵ [Sullivan C](#), [Leon JB](#), [Sayre SS](#), [Marbury M](#), [Ivers M](#), [Pencak JA](#), [Bodziak KA](#), [Hricik DE](#), [Morrison EJ](#), [Albert JM](#), [Navaneethan SD](#), [Reyes CM](#), [Sehgal AR](#). Impact of navigators on completion of steps in the kidney transplant process: a randomized, controlled trial. [Clin J Am Soc Nephrol](#). 2012 Oct;7(10):1639-45. doi: 10.2215/CJN.11731111

- Submitting the J-7 Short Form for the Transplant QIA by December 31st of option year 2
 - Describe the methodology devised to address barriers at each of 7 steps leading to receiving a transplant: 1) Patient suitability for transplant (defined as absence of absolute contraindication identified in the medical record), 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, 7) On waiting list or evaluate potential living donor.
 - Describing how Patient SMEs and/or family members or caregivers will be involved at the facility level in discussion about transplant benefits, requirements, barriers, and successful interventions to overcome barriers.
- Identifying at least 30% of the dialysis facilities within the Network's service area regardless of modality to participate in the Transplant QIA.
- Tracking and reporting to CMS monthly on the DIF the number of patients at each stage of the process as the patients are successfully moved to the next step of the process.
- Reporting the number of patients added to a transplant waitlist monthly in the DIF as directed by this SOW or through supplemental CMS communication.
- Providing a list of the facilities identified to participate in the Transplant QIA to the NCC by December 31st for option year 2.
- Engaging successful transplant recipients, transplant centers, and other stakeholders to develop educational materials to assist in overcoming identified barriers at each step of the process.
- Notifying the regional corporate representative for each facility selected for participation in the QIA and encouraged participation with the Network to the extent desired by the corporate representative.
- Encouraging facilities in the Transplant QIA to incorporate the process steps into patient education, facility practice, and the facility QAPI process.
- Using October – June of the previous year as provided by the NCC for baseline.
- Demonstrating at least a 10 percentage point increase in the rate of patients placed on a waitlist for transplant of eligible patients by evaluation of each option year based on data available in October.
- Using data provided by the NCC to identify new facilities to replace facilities that have 40% of the patients on the transplant waitlist and have improved internal process to ensure continued assistance of patients through the transplant process. The Network shall provide the list of facilities to be included in the QIA for option year 3 to the NCC by October 31st beginning in option year 2 and each subsequent option year.
- Using rapid cycle improvement to revise the methodology developed for the QIA and submit it to the COR by October 31st beginning in option year 2 for option year 3 and each subsequent option year. This shall allow for uninterrupted continuation of the QIA starting in December of subsequent option years.

Patients on the waitlist shall not be counted during the baseline of the project, as these patients will have already been counted or the process occurred outside of the timeframe of the project. The Network shall collect waitlist counts to be used as numerator data from target facilities. The ESRD NCC will provide to the Network, the number of prevalent patients to be used as the denominator.

C.4.3. Promote Appropriate Home Dialysis

Home dialysis modalities are underutilized in the USA with only 8% of the dialysis patients undergoing renal replacement therapy at home versus 92% being treated with center hemodialysis⁶. As a result, the following AIM with a 5-year target has been set to guide national health promotion and management to improve the health of all people in the United States living with ESRD: by 2023, **increase the number of ESRD patients dialyzing at home to 16%** from the 2016 national average of 12%. The intent of the Home Dialysis QIA is to promote referral to home dialysis modalities, identify and mitigate the barriers to timely referral, and determine the steps patients and providers can take to improve referral patterns. The Networks shall increase the number of patients on a home modality by participating in the ESRD NCC Home Dialysis LAN, and assisting dialysis facilities in the implementation of interventions to support patients through the process of training to dialyze at home.

C.4.3.A. Participate in the ESRD NCC Home Dialysis LAN

The ESRD NCC Home Dialysis LAN has three primary purposes. The first is to improve information communication across care settings, with emphasis on communication between in-center dialysis centers and home dialysis centers to promote and support transition of care for ESRD patients. The second is to promote and support communication internally between in-center and home modality staff to educate patients. The third is to increase awareness of and ways to support the patient through training for a home modality.

The Network shall perform the following to support ESRD NCC Home Dialysis LAN:

- Invite all facilities within the Network service area to participate.
- Invite QIN-QIO(s), HIINs, State Survey Agencies, hospitals, both in-center and home dialysis facilities including regional leadership, and patient representatives to support communication and Home Dialysis QIA. At a minimum the Network shall ensure there is a participating cohort formed by all facilities participating in the Home Dialysis QIA, a minimum of two (2) home dialysis centers from each state in the Network service area, and two (2) patients, family members and/or caregivers from each state in the Network service area.
- Ask dialysis organizations to identify facilities within the Network service area that have successfully implemented process to support patients through transition to a home modality.
- Provide a list of participants for the NCC Home Dialysis LAN by December 31st of option year 2.
- Provide an updated list of participants for the NCC Home Dialysis LAN by October 31st of option year 2 for option year 3.
- Provide an updated list of participants for the NCC Home Dialysis LAN by October 31st for each subsequent option year.
- Attend the ESRD NCC Home Dialysis LAN every other month.
- Share identified interventions to improve the home dialysis rates from each LAN meeting with all facilities in the Network service area and report on the implementation of the

⁶ Thinking outside the box—identifying patients for home dialysis. [Brigitte Schiller](#), [Hayley Munroe](#), and [Andrea Neitzer](#)

interventions at QIA facilities in the monthly COR report.

C.4.3.B. Increase Rates of Patients Dialyzing at Home

The Network shall work through facilities to increase the number of patients dialyzing at home by:

- Submitting the J-7 Short Form for the Home Dialysis QIA by December 31st of option year 2
 - Describing the methodology devised to address barriers at each of 7 steps leading to home dialysis utilization: 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, 4) Placement of appropriate access, 5) Patient accepted for home modality training, 7) Patient begins home modality training.
 - Describing interventions to increase the awareness and education on home modality options and referral to home dialysis, for those patients recently initiating dialysis within the previous 6 months. Research shows that, "The study was a bit underpowered so some of our outcomes were not statistically significant. However, we know from four years of work in addition to the RCT [Randomized Controlled Trials] that our results are consistent: with over 800 patients treated, preemptive transplant is sharply increased, home dialysis rates and placement of arteriovenous fistulas for in-center hemodialysis are greatly increased, and that initiation of hemodialysis without a hospitalization is consistently achieved."⁷
 - Describing interventions to ensure appropriate reassessment of modality choice. Changes in life events could also change receptiveness to home modality.
 - Describing how Patient SMEs and/or family members or caregivers will be involved at the facility level in discussion about home dialysis benefits, requirements, barriers, and successful interventions to overcome barriers.
- Identifying at least 30% of dialysis facilities providing in-center dialysis care within the Network's service area to participate in the Home Dialysis QIA.
- Tracking and reporting to CMS monthly on the DIF the number of patients at each stage of the process and the number of patients that are successfully moved to the next step of the process.
- Reporting the number of patients training for a home dialysis modality monthly in the DIF as directed by this SOW or through supplemental CMS communication.
- Providing a list of the facilities identified to participate in the Home Dialysis QIA to the NCC by December 31st for option year 2.
- Engaging patients successfully dialyzing at home, home dialysis centers, and other stakeholders to develop educational materials to assist in overcoming identified barriers at each step of the process.

⁷ Neumann, ME. Can Augmented Care in CKD Stages 4-5 Change the Path to ESRD?
<https://www.nephrologynews.com/can-augmented-care-ckd-stages-4-5-change-path-esrd/>

- Notifying the regional corporate representative for each facility selected for participation in the QIA and encouraged participation with the Network to the extent desired by the corporate representative.
- Encouraging facilities in the Home Dialysis QIA to incorporate the process steps into patient education, facility practice, and the facility QAPI process.
- Using October – June of the previous year as provided by the NCC for baseline.
- Demonstrating at least a 10 percentage point increase in the rate of patients that start home dialysis training by evaluation of each option year based on data available in October.
- Using data provided by the NCC to identify new facilities to replace facilities that have 40% of the patients trained or in training for home dialysis and have improved internal process to ensure continued assistance of patients through transition to home. The Network shall provide the list of facilities to be included in the QIA for option year 3 to the NCC by October 31st beginning in option year 2 and each subsequent option year.
- Using rapid cycle improvement to revise the methodology developed for the QIA and submit it to the COR by October 31st beginning in option year 2 for option year 3 and each subsequent option year. This shall allow for uninterrupted continuation of the QIA starting in December of subsequent option years.

C.4.4. Population Health Focused Pilot QIAs

The Network's activities shall focus on improving the quality of care and access to ESRD care through a Population Health Focused Pilot QIA (PHFPQ) in one of the following CMS pre-approved priority areas:

- Improve Dialysis Care Coordination with a Focus on Reducing Hospital Utilization (QIA A1, A2, or A3)
- Positively Impact the Quality of Life of the ESRD Patient with a Focus on Mental Health (QIA B)
- Support Gainful Employment of ESRD Patients (QIA C)
- Positively Impact the Quality of Life of the ESRD Patient with a Focus on Pain Management (QIA D)

The objective of the PHFPQ is to facilitate achievement of national quality improvement goals and support statutory requirements set forth in Section 1881 of the Social Security Act and the Omnibus Budget Reconciliation Act of 1986. Throughout this PHFPQ, the Network shall provide leadership and guidance for the QIA's quality improvement efforts in collaboration with the CMS SME and COR.

In OY 1 and OY 2, each Network shall conduct one QIA per contract year and shall achieve the performance requirements for the QIA selected (i.e., A1, A2, B, C, or D) for evaluation purposes, as well as demonstrate reduction in an identified disparity (for applicable QIAs), as required by this SOW. In OY 3 and OY 4, all Networks shall conduct the National Hospital Care Coordination QIA (QIA A3), using methodology developed by CMS. CMS will further determine if the Network will be required to select and complete a second PHFPQ for another focus area.

C.4.4.A. Population Health Focused Pilot QIAs: Technical Considerations

The Network's PHFPQ shall adhere to the confidentiality and disclosure requirements set forth in Section 1881 of the Social Security Act, the Omnibus Budget Reconciliation Act of 1986, and all applicable CMS administrative directives.

Any data given to the Network by the government for purposes of a PHFPQ shall only be used to support the PHFPQ unless the Contracting Officer specifically permits another use in writing. If the Contracting Officer allows the Network to use government-supplied data for a purpose other than one solely in support of this PHFPQ, and if such use could result in a commercially viable project, the Contracting Officer may negotiate a financial benefit to the government. A benefit may be in the form of a reduction in the price of the PHFPQ, but the Contracting Officer may negotiate any other benefit(s) he/she determines are adequate compensation for the use of the data.

At the request of the Contracting Officer or at the completion of these PHFPQs (whichever comes first), the Network shall return or destroy all data related to the PHFPQ given to the Network by the government. The Contracting Officer may direct that the data be retained by the Network for a specified period of time agreed to by the Network. If the data are to be destroyed, then the Network shall furnish direct evidence of such destruction in a form that the Contracting Officer shall determine is adequate.

The Network shall comply with all CMS guidelines regarding the appropriate de-identification of data related to both individuals and facilities, consistent with the guidelines concerning disclosure of ESRD data.

C.4.4.B. Population Health Focused Pilot QIAs: Requirements

The Network shall, working with appropriate internal and external stakeholders for the Network-selected QIA and implementing proven quality improvement techniques, develop the QIA and interventions based on the findings of the RCA conducted. To meet established thresholds, the QIA shall incorporate the concepts of boundariliness and unconditional teamwork into innovative approaches that are customer-focused and sustainable. The QIA plan shall include rapid cycle improvement strategies.

CROWNWeb data will be the official data source for all QIAs. Other CMS-sanctioned data collection systems may be used, as decided by CMS. In the proposal phase, the Network shall use CMS-identified data sources and establish measurable outcomes for consideration and CMS approval. Data collected throughout these QIAs shall be used to impact quality improvement in the care delivered to ESRD patients and to identify trends that may be indicative of disparities in care, with the purpose of decreasing such disparities.

The Network should be knowledgeable in the topic area and the targeted populations that it is working with during the course of these QIAs. QIAs shall also be developed so that, if necessary, participating dialysis facilities may be carried into future contract periods or replaced if they have achieved pre-determined thresholds for the measures.

Using ESRD NCC-provided data, the Network shall select a topic for its PHFPQ based on (a) the opportunity for improvement on the performance measure in the target population and (b) the ability to reduce an identified disparity (for applicable QIAs).

As the first step in choosing the target facilities for its PHFPQ, the Network shall select from one of the four CMS-approved QIA areas. The Network shall then determine from the baseline data whether >25% of the target population demonstrated the desired outcome(s) for the selected topic area. If $\geq 25\%$ of the target population demonstrated the desired outcome(s), then the Network shall select one of the other QIA areas that would meet the <25% criterion.

The Network shall then conduct a disparity assessment using baseline data provided by the ESRD NCC, if selecting QIA B, QIA C, or QIA D. In OY 2, a disparity assessment is not required for QIA A. The disparate categories that follow shall be assessed based on the category having the greatest point difference between the designated categories, as determined by ESRD NCC calculation.

- Age (65 and older vs. 18-64),
- Ethnicity (Hispanic vs. Non-Hispanic),
- Facility Location (Rural vs. Urban),
- Gender (Female vs. Male), or
- Race (Populations Other than White, including African American or Asian or Native American or Pacific Islander, etc. vs. White).

The disparate category with a ≥ 5 point difference between the designated categories, as demonstrated by ESRD NCC provided data, will be used for the QIA. Once the final QIA is approved, the disparity cannot be further modified for the remainder of the contract year.

For this multi-year contract with a base year and four Option Years (OYs), the Network shall obtain CMS approval of the QIA facilities and disparity prior to initiating formal intervention activities related to the QIA. The Network shall initiate the QIA by selecting the topic area, target facilities and disparity to be included in the QIA. If the Network decides to continue the QIA from the previous contract year, it shall replace any facilities that have achieved the threshold where at least 75% of the facility patient population achieved the desired outcome. For example, if a facility started the base contract period with 10% of its patients with an employment referral, and at the end of base contract period has achieved 80% of its patients with a referral to a State Vocational Rehabilitation Agency or an Employment Network, this facility would be replaced by another facility that is below the 25% threshold for inclusion.

Additionally, if the Network stays with the same QIA, it may add facilities that otherwise meet the PHFPQ and topic-specific requirements, and it may petition to have facilities dropped that otherwise either do not meet the requirements of the QIA or have other legitimate reasons for being excluded from the QIA. Legitimate reasons for exclusion include: a facility no longer provides the services related to the topic area (e.g., a dialysis facility stops providing home dialysis services), permanent closure (temporary closure is not a legitimate reason unless documentation is received from the facility that the closure will be of sufficient length that the facility would not be able to participate in the QIA for at least six months of the contract period), or a facility has participated in a QIA for longer than three contract years. All final decisions on

the legitimacy of the exclusions will rest with the PHFPQ CMS SME.

For each Option Year of the contract, an initial plan for the QIA, due by December 15, shall be provided, using the PHFPQ Checklist in Attachment J-7, Quality Improvement Activities. The completed PHFPQ Checklist shall explain in detail the strategies, interventions and timeframes the Network plans to implement in order to meet all of the specified goals of the QIA. The Network is responsible for developing and/or identifying interventions that improve the condition of the selected QIA demographic (i.e increase the number of patients referred to a State Vocational Rehabilitation Agency or an Employment Network) **and** reduce the disparity for the highest-ranking disparate group (for applicable QIAs). All proposed interventions for the selected QIA shall be reviewed and approved by the Network MRB, prior to implementation, with acceptance and/or rejection recorded in meeting minutes. The proposal shall be finalized and baseline data collection and analysis for the selected QIA shall be completed, by the last business day in December. The Network shall not opt for a different QIA after PHFPQ approval is received by the last business day in December. Reporting of the final QIA target facilities to the NCC shall be completed by January 8 for the Option Years of the contract.

A root cause analysis for each participating QIA facility, identifying specific inefficient processes, ineffective practices and barriers to quality service and proposing specific interventions, shall be submitted to the COR and CMS SME and finalized by January 25 of OY2. The RCA shall be completed using the PHFPQ Root Cause Analysis Template in Attachment J-7, Quality Improvement Activities. Intervening approaches shall begin by the first business day of February. The evaluation period for all PHFPQ QIAs shall be from January through September.

The Network shall invite all facilities in the Network service area to participate in the Pilot QIA specific NCC led LAN. The Network shall invite all facilities participating in the specific Pilot QIA, and two (2) patients, family members and/or caregivers from each state in the Network service area. The Network shall work with dialysis organizations to identify facilities within the Network service area that have successfully developed internal process related to the specific Pilot QIA to include in the LAN. The LAN shall meet every other month. The Network shall share identified interventions to improve specific Pilot QIA rates from each LAN meeting with all facilities in the Network service area and report on the implementation of the interventions at QIA facilities in the monthly COR report. The Network will provide a list of participants for the NCC by December 31 of each option year.

C.4.4.C. Population Health Focused Pilot QIAs: Contract Monitoring and Evaluation

The PHFPQs present new opportunities for the Network to identify, implement and spread promising practices, thereby improving the quality and efficiency of services rendered to ESRD patients.

The Network shall be monitored and measured for improvement through routine COR Review, based on data reported to CMS. Data for the Network-selected QIA shall be reported to CMS monthly using the CMS DIF, as directed by CMS through this SOW or through supplemental CMS communication. The Network shall submit all required reports and deliverables in accordance with the SOD. Failure to meet all requirements of a chosen QIA (including, but not

limited to, data reporting for all components of the QIA, achievement of topic-specific performance requirements, specific requirements related to disparity reduction, and achievement of required attribute evaluation goals) will be referred to the Contracting Officer for determination of appropriate action.

For each year of the contract, evaluation of this QIA shall be based on three components weighted equally: 1) achievement of the topic-specific performance benchmark (quantitative assessment), 2) reduction in the disparity (for applicable QIAs), (quantitative assessment) and 3) successful incorporation of the six identified attributes into the QIA (qualitative assessment). Successful performance for these three objectives shall be determined by mutual agreement between the COR and CMS SME. The evaluation period of each of these measures shall be based on data occurring between January and July for the performance and disparity measures, assessed against a baseline period of October – June of the previous contract year. CMS will re-establish baselines each contract year, regardless of whether the QIA is for a single year or spans multiple-years.

The quantitative evaluation of the PHFPQs shall be based on successful:

- a) Achievement of the required performance improvement for the targeted demographic of the selected QIA, as of July CROWNWeb data (received in October), as specified in this SOW; and
- b) Relative improvement of the project patient pool percentage for the disparity, for applicable QIAs.

To achieve the disparity reduction requirement, the Network should improve the disparaging condition of the disparate population by the CMS-designated improvement goal from the baseline (October – June of the previous year). The non-disparate group must at a minimum not be negatively impacted by the implemented interventions, while the disparate group improves. A decline for the initially higher-performing group will not be considered as successful completion of the QIA, even if such a decrease lowers the overall rate of disparity.

The ESRD NCC will provide to the Network, a calculation of the disparity rate for both the disparate and non-disparate groups. The Network shall, for baseline determination and re-measurement each month, use the calculation of the disparity rate provided by the ESRD NCC to monitor improvement for the selected disparate population.

Failure in either quantitative component shall result in an unsuccessful evaluation for the QIA.

The qualitative evaluation of the PHFPQs shall be based on successful incorporation of the six (6) identified attributes, as determined by Network COR assessment. The Network shall provide tangible evidence of demonstrations of the six attributes in each QIA on a monthly basis during the monthly COR call, including actions that support or facilitate incorporation of the attribute. The COR will monitor for inclusion of the six attributes and demonstrations of each attribute throughout the course of the QIA, reporting progress in the COR Monthly Report and providing an assessment of incorporation of the attributes on the CMS ESRD Dashboard. Demonstrations

of attributes shall be displayed for each month of the QIA; therefore, the Network shall not have a month in which the attribute is shown as N/A.

The following attributes of effective QIAs will serve as the basis for assessing qualitative performance under PHFPQ:

1) Commitment to Boundarilessness and Unconditional Teamwork: To display the concept of boundarilessness, the Network shall demonstrate the ability to identify and engage various entities outside of CMS, to impact improvement for ESRD patients and/or providers. Entities outside of CMS, include (but is not limited to) state, local and federal healthcare organizations; patient advocacy groups; professional associations; and stakeholders. These entities should be a full and active participants in the QIA. The Network shall be able to identify entities not typically included in the QIA and how the collaboration with the external entity is improving the outcomes of the QIA.

To display the concept of unconditional teamwork, the Network shall demonstrate its ability to, at minimum, partner with other Networks; divisions internal to CMS; the ESRD NCC; and QIN-QIOs; to solicit input from dialysis facilities, patients and others in the renal community to identify, develop and spread effective improvement activities. The Network shall demonstrate sharing of best practices with other Networks, as well as with QIA participants and partners. Demonstrations may include, but are not limited to: active participation on COP calls, engaging meeting presenters to identify new and different approaches, collaborations with QIN-QIOs, and participating in NCC QIA Workgroups, including dynamic discussion and exchange of ideas with other Networks.

Both attributes must be demonstrated, either separately or in a single effort.

Attribute in Action (Boundarilessness): The Network partners with the American Association of Kidney Patients (AAKP) to develop an outreach and awareness campaign for the promotion of home dialysis.

Attribute in Action (Unconditional Teamwork): The Network joins the Community Care Coordination Coalition of one of the QIN-QIOs located in their geographic region. As an active member of the Coalition, the Network participates on activities to identify barriers and improve the coordination of care within chronic care settings.

Attribute in Action (Boundarilessness & Unconditional Teamwork): The Network includes in its approach to QIA A, collaborative practice with a QIN-QIO; the regional referral hospitals of QIA dialysis facilities; QIA dialysis facilities; and community nursing homes, forming a regional coalition aimed to improve the health of dialysis patients through better facilitated communication between all providers involved in the care process.

2) Customer Focus and Value of the QIAs to Patients, Participants, and CMS: The Network shall seek to meet the needs of its customers by involving patients and other stakeholders in all aspects of QIAs. Customer input should help to shape the design and ongoing operations of

activities. Patients representing the diversity of the population served shall be actively engaged in activities. The Network shall be able to demonstrate that patients and other stakeholders were solicited for feedback on: the relevance of a specific QIA to the patient or stakeholder, how well a particular QIA met the needs of the patient or stakeholder, whether or not the QIA impacted a significant change for the patient or stakeholder, and/or additional suggestions for improvement. The ability of the Network to address these topics in a direct and actionable manner will be evidence of meeting the requirements for this attribute.

Attribute in Action: The Network offers an electronic survey, monthly to all dialysis facility QIA leads, to solicit feedback and suggestions regarding the design and ongoing execution of the PHFPQ QIA. Responses are reviewed and documented and discussed in the steering committee, for appropriate action.

3) Value Placed on Innovation: The Network shall demonstrate solicitation and/or creation of at least one a new idea or concept that maximizes improvement for the QIA participants. This includes developing a mechanism by which all entities the Network works with and/or has contact with as part of the QIA are able to contribute ideas that may be of value to the Network's improvement work. It may also include the development of one or more new tools or processes that benefit the QIA participants. The Network shall be able to demonstrate examples of these approaches as part of its QIA. To demonstrate innovation, an intervention must be a new concept or approach to the Network. Once an intervention has been established in a Network's service area, that specific intervention may no longer be viewed as innovative; however, if thru the rapid cycle improvement process, the intervention is improved, the revised approach may be considered innovative.

Attribute in Action: The Network provided web cameras to those QIA facilities in remote areas where travel to and from those facilities was difficult. With the installation of the cameras, the Network conducted virtual site visits and QIA update meetings with facility staff.

4) Patient and Family Engagement: The Network shall provide technical assistance to dialysis facilities on developing strategies to promote and encourage Patient SMEs and/or family members or caregiver participation with the PHFPQ QIA. The Network shall demonstrate assessment at the dialysis facility level for Patient SMEs and/or family members or caregiver involvement on task forces and teams working on patient safety and quality improvement endeavors related to the selected QIA. At the Network level, Patient SMEs and/or family members or caregivers shall be instrumental in the planning, development and selection of interventions and tools that support advancement of the PHFPQ QIA. As part of QIA update meetings with dialysis facilities or any onsite visits to dialysis facilities participating with the PHFPQ QIA, the Network shall incorporate discussion, education and evaluation of how the dialysis facility has implemented patient and family centered care into the selected PHFPQ QIA. During these meetings, the Network shall assess for the presence of quality improvement focused meetings including: Patient SMEs and/or family members or caregivers (e.g., patient council, LANS, QAPI meetings); patient and family involvement in the governing body of the facility; and policies and procedures related to family participation in the patient's care (e.g., involvement in the development of the individualized plan of care and decisions about mental health treatment

or employment). A summary of the related findings and actions taken, resulting from these discussions/visits and documentation of patient and family engagement at the facility level shall be documented in the COR Monthly Report.

Attribute in Action: In response to numerous accounts of feelings of isolation, the Network established a patient-led support group for those patient residing in rural areas.

5) Rapid Cycle Improvement in QIAs and Outputs: The Network shall routinely reassess the value of the interventions and technical assistance used for the QIA. The Network shall make interim adjustments based on the feedback it receives from its participants and CMS, as well as from its own performance monitoring toward achieving contractual goals. The Network shall report what changes have been made in regard to the performance and/or disparity components of the QIA, why they were made, and how they are expected to impact the QIA metrics. Examples of evidence include that the Network demonstrates that results and the impact of interventions are reviewed on at least a monthly basis, adjustments are made to the interventions and that interventions that do not yield positive results are discontinued.

Attribute in Action: The Network identifies a risk calculator, developed by a university's School of Medicine. The MRB researches and reviews the tool, which shows estimates for a patient's risk of survival and death with different treatment options, based on age, gender, length of time on dialysis, and patient history. The Network introduces the tool to the PAC aiming to increase dialogue regarding patient treatment options and to help patients make better educated treatment decisions. The Network disseminates a pre-test to ¼ of the PAC members. For two weeks, the small group of PAC members uses the calculator. The Network administers the pre-test again (now a post-test) to measure if patients' knowledge of treatment options had increased. Patient SMEs recommend a change in the way the tool is disseminated and explained. The Network administers the pre-test to another ¼ of the PAC members and tests the new approach for two weeks, administering the post-test afterwards. Noticing improved results compared to the first round of testing, the Network disseminates the calculator to the remaining ½ of the PAC members using the revised approach. After two weeks, receiving a few more suggestions, but recognizing consistent outcomes, additional tweaks are made and the calculator is disseminated to all QIA facilities.

6) Ability to Prepare the Field to Sustain the Improvement: Early in the QIA, the Network shall begin establishing a plan to increase the probability that the quality improvement activity(s) are maintained and that improvement continues when the Network completes its formal work with the participants. The Network shall provide a framework and education for the QIA participants that will allow them to sustain or continue improvement in the absence of the Network. The Network shall demonstrate how the facilities involved in the PHFPQ are able to incorporate the interventions into their own activities and processes in order to sustain the QIA once the Network's involvement is completed. The Network may develop a new QIA while the interventions developed in a former QIA remain in use. Examples of demonstrated sustainment include process changes facilities have implemented or new approaches that the facilities have undertaken that directly impact future results.

Attribute in Action: As an intervention for QIA A, the Network supports facilities in implementing post-hospitalization evaluations for patients during the first treatment, post hospitalization. Through frequent dialogue with LDO leadership throughout the QIA and by demonstrating successful outcomes of the intervention, the LDO now requires a new dialysis order from the nephrologist prior to the first treatment, post hospitalization. The order includes key sections from the post-hospitalization evaluation.

C.4.4.D. QIA A1: Improve Dialysis Care Coordination with a Focus on Reducing Hospital Utilization

“Transition of care between settings is a critical part of care coordination and is particularly complex for kidney patients. Approximately 35% of hospitalized dialysis patients are re-hospitalized within one month, often for the same problem that caused the first hospitalization. Good discharge processes can decrease the risk of re-hospitalization, but many other processes are also important for safe transitions”.⁸ The intent of QIA A is to identify the drivers of ineffective care transitions such as a lack of timely and complete communication, poor patient activation, and other system level process deficiencies that can lead to poor health outcomes resulting in increased utilization of acute care services. QIA A also serves to aid the Network in identifying and implementing appropriate facility-level interventions that improve the care coordination for ESRD patients and their family members between care settings.

In support of QIA A, the Network shall perform specific root cause analyses of unplanned hospital admissions in QIA dialysis facilities, identifying/developing and implementing evidenced based interventions that improve the overall rate of unplanned hospitalizations in the Network. An unplanned hospitalization is one that is designated in CROWNWeb as “ER Visit Resulted in Hospitalization”. The Network shall coordinate the QIA by involving appropriate stakeholders, including at minimum, at least one QIN-QIO within the Network’s geographic territory. The Network shall include in the QIA at least 10% of the dialysis facilities within the Network’s geographic territory. The target facilities shall be selected from those facilities in the top 25th percentile for patients with unplanned hospitalizations. Measurement will be obtained from CMS-specified hospital measures in CROWNWeb, with data reported to CMS for the targeted facilities on a monthly basis. Numerator and denominator figures for QIA A will be provided by the ESRD NCC. In conjunction with the intervention strategies selected by the Network, the Network shall conduct, by the last business day in January, a “QIA kickoff” meeting with the selected referral hospitals and those dialysis facilities that primarily refer to those medical centers, to explain the QIA in detail and allow opportunity for QIA participants to communicate specific needs and barriers experienced. QIA kick-off meetings may be conducted virtually, if necessary and most convenient for participants. The Network shall document meeting discussion in official meeting minutes. The Network shall also disseminate to QIA participants (hospitals and dialysis facilities) the Transitions of Care Toolkit developed by the Forum of ESRD Networks’ Medical Advisory Council, reviewing chapters 1, 5, and 8-10 with dialysis facilities. QIA results shall be reported to CMS on a monthly basis, as directed by this SOW or through supplemental CMS communication.

⁸ Medical Advisory Council, Forum of ESRD Networks. Transitions of care toolkit. Birchwood (WI): Forum of ESRD Networks; 2017 [cited 2017 Jul 6]. Available from: <http://esrdnetworks.org/resources/toolkits/mac-toolkits-1/new-toolkit-transitions-of-care-toolkit>.

Evaluation of QIA A1 shall be based on two components weighted equally: 1) achievement of the topic-specific performance benchmark (quantitative assessment) and 2) successful incorporation of the six identified attributes into the QIA (qualitative assessment). Successful performance for these two objectives shall be determined by mutual agreement between the COR and CMS SME. The participating Network shall achieve a 2-point decrease in the average rate of overall hospitalizations from the baseline period (October – June of the previous contract year), each year the QIA is conducted and a 10% decrease in ESRD related hospitalizations. The Network shall demonstrate that at least two root causes for hospitalizations have been identified with appropriate, evidenced based interventions implemented.

C.4.4.D. QIA A2: Network Workgroup Focus on Reducing Hospital Utilization

As an alternative to PHFPQ-QIA A1 (Improve Dialysis Care Coordination with a Focus on Reducing Hospital Utilization), CMS will work with up to six Networks to further explore the issues surrounding unplanned hospitalizations in the ESRD population. This effort will specifically be under the direction of CMS for the activities, including interventions to be implemented. If the Network decides to apply for consideration to participate and is selected by CMS, the Network agrees to be an active member of a workgroup of up to six (6) Networks working collaboratively to assess the issues surrounding unplanned hospitalizations and to test intervention strategies for consideration of future use in this task area. If selected, the Network agrees to participate in the QIA for the entire QIA year.

The Networks within this workgroup shall:

- a) Actively participate in scheduled workgroup meetings throughout the QIA year, including but not limited to, discussions of measurement, interventions and proposed next steps for advancing CMS's ability to impact unplanned ESRD hospitalizations;
- b) Identify as a QIA participant, at least one QIN-QIO or state hospital association within their ESRD Network territory to actively collaborate on QIA outcomes;
- c) Identify as QIA participants, three (3) to five (5) medium-sized hospitals that:
 - a. Are capable of providing chronic dialysis services to inpatients either through their own capability or arrangements with another provider, and
 - b. Transfer less than 10% of their ESRD patient population to other healthcare facilities due to inability to meet medical needs (e.g., need to transfer to a burn unit, trauma facility);
- d) Identify as QIA participants, 10 to 15 dialysis facilities whose patients are admitted or use the Emergency Department services at the hospitals specified in (c), maintaining at least 10 QIA facilities throughout the QIA;
- e) Complete facility specific root cause analyses with each QIA dialysis facility;
- f) Initiate a process for QIA dialysis facilities to receive ESRD patient medical record information from participant medical centers;
- g) Conduct a "QIA kickoff" meeting with the selected referral hospitals and those dialysis facilities that primarily refer to those centers, to explain the QIA in detail and allow an opportunity for QIA participants to communicate specific needs and barriers experienced;
- h) Ensure that a post-hospitalization assessment is completed for each patient having an unplanned admission between January 1 and August 30 of the QIA year; and

- i) Disseminate to QIA participants (hospitals and dialysis facilities) the Transitions of Care Toolkit developed by the Forum of ESRD Networks' Medical Advisory Council, reviewing chapters 1,5, and 8-10 with dialysis facilities

The interventions specified above are not intended to be an exhaustive list of implemented interventions, as the Network is also expected to identify interventions that specifically address the root cause of unplanned hospital admissions at each dialysis facility.

Evaluation of QIA A2 shall be based on two components weighted equally: 1) achievement of the topic-specific performance benchmark (quantitative assessment) and 2) successful incorporation of the six identified attributes into the QIA (qualitative assessment). Successful performance for these two objectives shall be determined by mutual agreement between the COR and CMS SME. The participating Network shall achieve a 1-point decrease in the average rate of overall hospitalizations from the baseline period (October – June of the previous contract year), each year the QIA is conducted and a 7% decrease in ESRD related hospitalizations.

The participating Network shall collect, assess, and report results all five of the disparity categories, where possible, based on the hospitals and dialysis facilities included in the QIA. No disparity reduction shall be required, but a report of results for the performance measures and the applicable disparity categories shall be provided through the CMS DIF on a monthly basis.

The participating Network shall provide presentations as requested by CMS at the Quality Conference or other appropriate venues to inform on the findings and progress of workgroup activities.

The Networks shall submit the PHFPQ QIA Checklist by December 15, selecting QIA A2, in order to be considered for participation in the workgroup. Consideration by CMS will be based on geographic representation by the workgroup members, the ability of the Network to identify appropriate hospitals and dialysis facilities for inclusion in the QIA and the Network's ability to impact and sustain quality improvement in the QIA. Networks will be selected for this QIA by the PHFPQ CMS SME, with notification to the Network occurring no later than last business day of December of each option year of the contract.

C.4.4.D. QIA A3: National Care Coordination QIA

For OYs 3 and 4, all Networks shall participate in a National Care Coordination QIA as directed by CMS. All QIA details, including measures and methodology, will be developed by CMS, with consideration of feedback and findings from QIA A2 workgroup members, and distributed to all Networks prior to the initiation of the third OY. The Network shall provide the COR with the target population by the last business day of December for OY3 and OY4. The Network shall follow all CMS direction related to this QIA without deviation.

C.4.4.E. QIA B: Positively Impact the Quality of Life of the ESRD Patient with a Focus on Mental Health

The intent of QIA B is to improve the screening and treatment of depression for ESRD patients. "Depression is the most common psychological disorder in end-stage renal disease (ESRD) patients with a prevalence rate as high as 20% to 25% by some contemporary estimates. There

are several studies linking depression with mortality in ESRD, making early diagnosis and treatment essential”.⁹

The Network shall provide to dialysis facilities technical assistance with developing a process to ensure the completion, documentation and appropriate follow-up of an annual depression screening for 100% of qualifying patients, as determined by the CY 2017 ESRD PPS Final Rule (2016). If a diagnosis of clinical depression is made, treatment options shall be tailored to the specific needs of the patient and the resources available to the dialysis facility. Each diagnosed patient shall have an individual assessment completed with appropriate action taken or shall have a treatment plan developed.

“Patients with moderate to advanced CKD and ESRD have generally been excluded from large antidepressant trials because of concerns for adverse events and the paucity of data on safety of antidepressants in this population”.¹⁰ In partnering with dialysis facilities, the Network shall increase awareness of and encourage consideration of nonpharmacologic interventions, including but not limited to, art therapy, cognitive behavioral therapy, exercise training programs, and music therapy.

The Network shall include in the QIA, at least 10% of the dialysis facilities within the Network’s service area with the highest response rate to either “Clinical depression screening not documented, and no reason is given” or “Screening for clinical depression documented as positive, the facility possesses no documentation of a follow-up plan, and no reason is given”. The ESRD NCC will provide to the Network, based on CROWNWeb, the number of patients reported as screened to be used as the numerator and to be used for the denominator, the number prevalent patients. Successful completion of QIA B will be evaluated based on the percentage of patients screened, the percentage of documented screenings and the percentage of documented follow-up plans, as reported in closed CROWNWeb data, by September of each option year. The Network shall decrease the response to “Clinical depression screening not documented, and no reason is given” to zero (0). The Network shall decrease the response to “Screening for clinical depression documented as positive, the facility possesses no documentation of a follow-up plan, and no reason is given” by 10%. QIA results for the targeted population shall be reported to CMS on a monthly basis as directed by this SOW or through supplemental CMS communication. The baseline for this QIA shall be October – June of the previous option year.

C.4.4.F. QIA C: Support Gainful Employment of ESRD Patients

The intent of QIA C is to assist ESRD patients with seeking gainful employment and/or returning to work.

The Social Security Administration (SSA) administers the Ticket to Work Program. Under this free and voluntary program, eligible beneficiaries between the ages of 18 and 55, who are blind or have a disability and receive Social Security Disability Insurance (SSDI) or Supplemental

⁹ Kimmel PL, Cukor D, Cohen SD, Peterson RA. Depression in end-stage renal disease patients: a critical review. *Adv Chronic Kidney Dis.* 2007;14(4):328-34.

¹⁰ Hedayati SS, Yalamanchili V, Finkelstein FO. A practical approach to the treatment of depression in patients with chronic kidney disease and end-stage renal disease. *Kidney Int.* 2012;81(3):247-55. doi: 10.1038/ki.2011.358. Epub 2011 Oct 19.

Security Income (SSI) benefits are entitled to sign up with an Employment Network (EN) or a State Vocational Rehabilitation (VR) agency of their choice. These approved service providers coordinate and provide appropriate services to help eligible beneficiaries find and maintain employment. Appropriate services may include training, career counseling, vocational rehabilitation, job placement, and ongoing support services necessary to achieve a work goal.¹¹

In support of QIA C, the Network shall identify a minimum of five (5) Employment Networks and/or the State Vocational Rehabilitation (VR) agency that serves the recruited patient population and educate patients regarding the researched and identified EN and/or VR resources. The Network shall demonstrate at least a five (5) percentage point increase in referrals to the identified EN and/or VR in by September 30th of the contract year. The Network shall demonstrate at least a two (2) percentage point improvement in the number of patients receiving EN and/or VR services in closed CROWNWeb data by September 30th of the contract year. The Network shall monitor the number of referrals that are received by the EN and/or VR. The ESRD NCC will provide to the Network, based on CROWNWeb, the number of patients reported as receiving EN and/or VR services to be used as the numerator and to be used for the denominator, the number prevalent patients between the ages of 18 and 55. The results shall be reported to CMS on a monthly basis, as directed by this SOW or through supplemental CMS communication. The Network shall include in the QIA, at least 10% of the dialysis facilities within the Network's service area. The baseline for this QIA shall be the number of patients identified in CROWNWeb as working in the patient demographics, in October – June of the previous option year.

C.4.4.E. QIA D: Positively Impact the Quality of Life of the ESRD Patient with a Focus on Pain Management

The Network shall provide to dialysis facilities technical assistance with developing a process to ensure the completion, documentation and appropriate follow-up of the twice annual pain assessment of qualifying patients, as determined by the CY 2017 ESRD PPS Final Rule (2016). If the pain assessment is documented as positive, treatment options shall be tailored to the specific needs of the patient and the resources available to the dialysis facility. Each patient shall have an individual assessment completed with appropriate action taken or shall have a treatment plan developed.

The Network shall include in the QIA, at least 10% of the dialysis facilities within the Network's service area with the highest response rate to either "No documentation of pain assessment, and no reason is given" or "Pain assessment documented as positive using a standardized tool, a follow-up plan is not documented, and no reason is given". The ESRD NCC will provide to the Network, based on CROWNWeb, the number of patients reported as screened to be used as the numerator and to be used for the denominator, the number prevalent patients. Successful completion of QIA D will be evaluated based on the percentage of patients screened, the percentage of documented screenings and the percentage of documented follow-up plans, as reported in closed CROWNWeb, by September of each option year. The Network shall decrease the response to "No documentation of pain assessment, and no reason is given" to zero (0). The Network shall decrease the response to "Pain assessment documented as positive using a

¹¹ Social Security Administration. Ticket to Work Program overview [cited 2017 Jul 6]. Available from: <https://www.ssa.gov/work/overview.html>.

standardized tool, a follow-up plan is not documented, and no reason is given” by 10%. QIA results for the targeted population shall be reported to CMS on a monthly basis as directed by this SOW or through supplemental CMS communication. The baseline for this QIA shall be October – June of the previous option year.