ESRD NETWORK 4 2020 ANNUAL REPORT

Quality Insights

Renal Network 4

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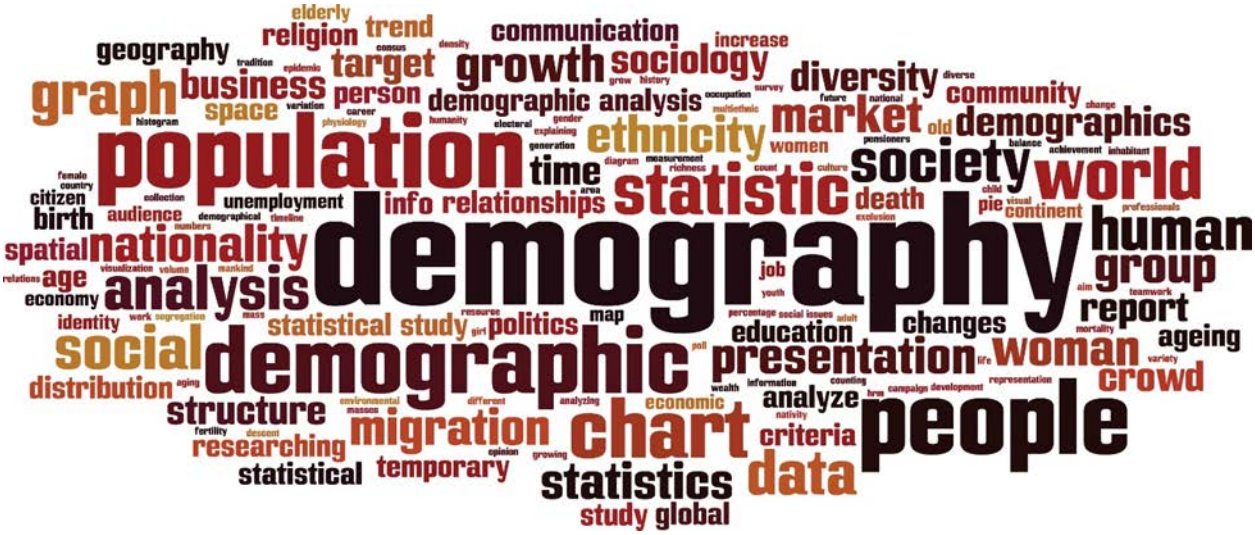
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ESRD DEMOGRAPHIC DATA

Quality Insights Renal Network 4 (QIRN4) is pleased to present our 2020 Annual Report. QIRN4 serves dialysis and transplant patients and providers in Pennsylvania and Delaware.

Corporate Affiliation

Quality Insights Renal Network 4 (QIRN4) is part of the Quality Insights family of health care improvement companies. In 2020, Quality Insights held the Medicare Quality Improvement Network-Quality Improvement Organization (QIN-QIO) contracts for Pennsylvania, and West Virginia and three ESRD Network contracts: Network 5 (covering Maryland, Virginia, West Virginia and Washington DC), Network 3 (covering New Jersey, Puerto Rico and the US Virgin Islands), and QIRN4.

Geographic Description

QIRN4 is responsible for two neighboring states, Pennsylvania and Delaware, which are located in the Northeast United States. As of December 31, 2020, there were 18,465 patients receiving dialysis services in the state of Pennsylvania. Those patients who were treated at an in-center hemodialysis center did so at one of 324 Medicare-approved dialysis centers, a Medicare-approved Veterans Administration Medical Center (VAMC) unit, or two non-Medicare-approved VAMC units.

Delaware, the other state in the Network 4 service area, is made up of three counties, spans 1,954 square miles, and is the fourth smallest state in the country. Delaware's location provides patients with easy access to several of the major metropolitan areas of the Northeast, including Washington, D.C., Philadelphia, and Baltimore. As of December 31, 2020, there were 1,820 patients were receiving dialysis services in the state of Delaware. Those who were treated at an in-center hemodialysis facility did so at one of 33 Medicare-approved dialysis facilities or at one non-Medicare-approved Veterans Affairs Medical Center (VAMC) unit.

As shown in Figure 1, as of December 31, 2020, there were 17,415 patients receiving treatment in dialysis facilities in the Network 4 service area, and an additional 2,870 patients receiving treatment in their homes. This total of 20,285 patients receiving dialysis, plus an additional 13,340 patients living with a functioning kidney transplant in the Network 4 service area brings the total ESRD patient count for this area to 33,625. As shown in Figure 2, in 2020 5,055 patients started dialysis in Network 4 facilities – 4,344 in-center and 711 at home. An additional 204 patients received a transplant before requiring dialysis.

The number of ESRD facilities in the Network 4 service area, by treatment modalities offered, is shown in Figure 3. During 2020 there were 19 transplant centers, 169 dialysis centers offering both in-center dialysis and home dialysis support, 181 dialysis centers offering in-center dialysis only, and 18 dialysis centers offering home dialysis support only, for a total of 368 dialysis centers and 387 centers that support ESRD patients.

Figures 4 through 9 illustrate the percentage of national totals of patients and facilities that those in the Network 4 service area constitute.

Figure 1- Number of Patients Treated in the Network 4 Service Area as of December 31, 2020 by Treatment Modality

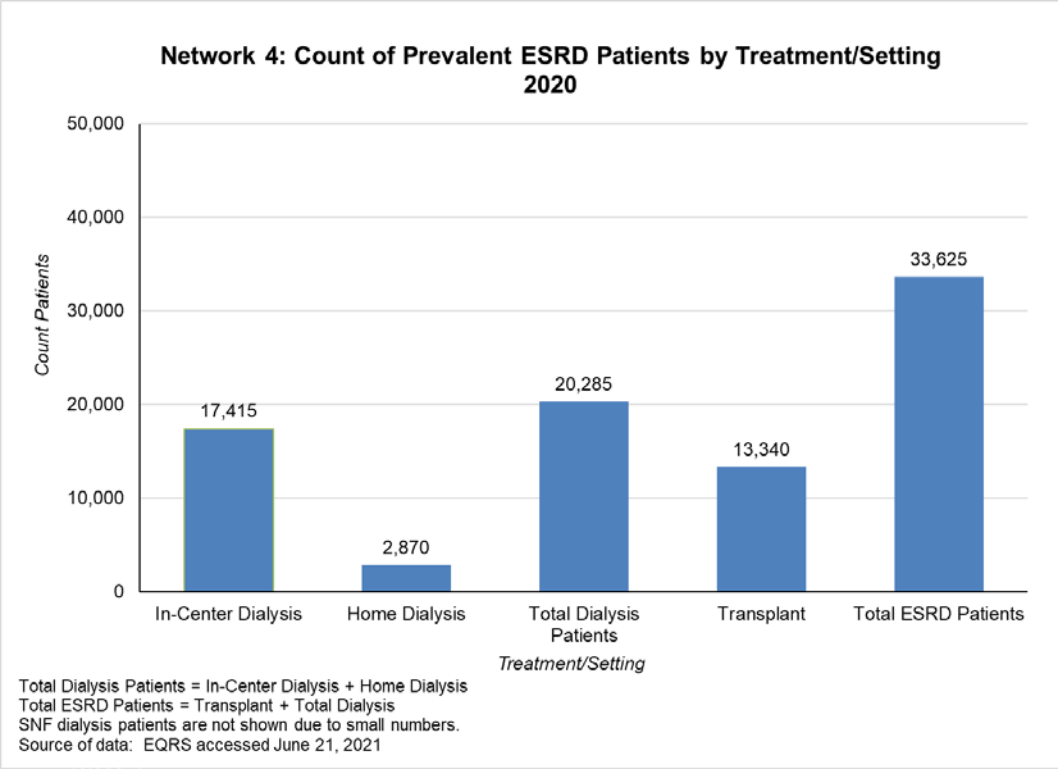


Figure 2- Number of Incident Patients Treated in the Network 4 Service Area in 2020 by Treatment Modality

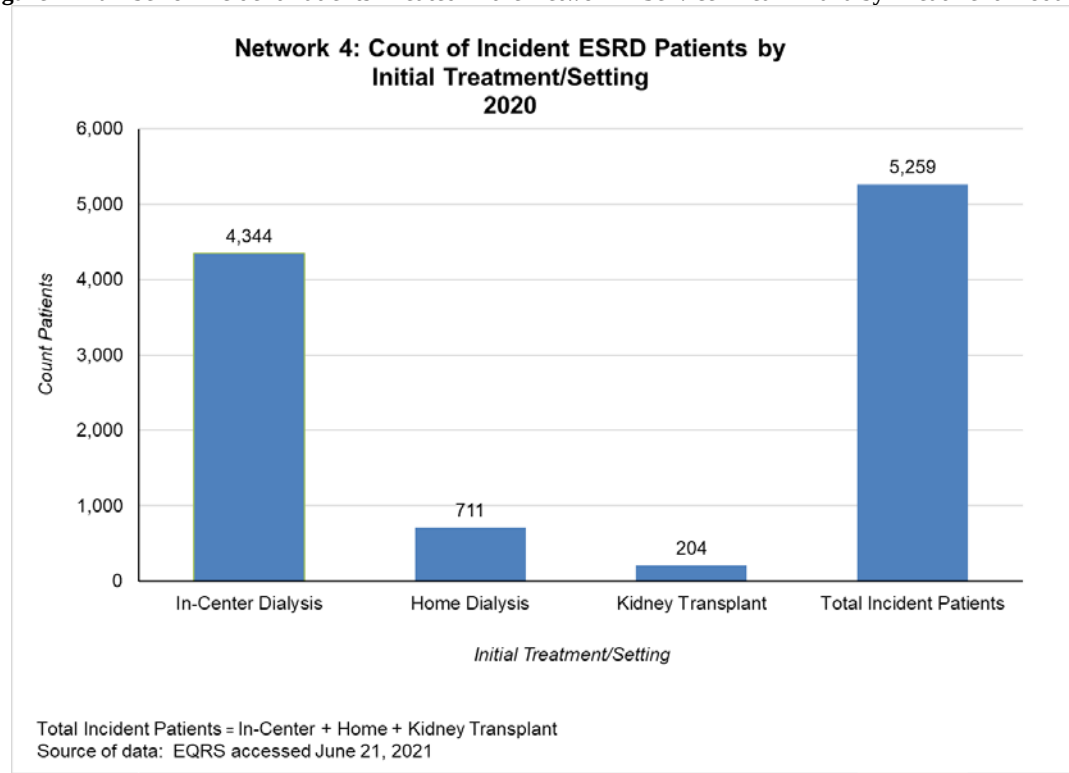


Figure 3 -Number of Medicare-Certified Facilities in the Network 4 Service Area by Modality Offered as of 12/31/2020

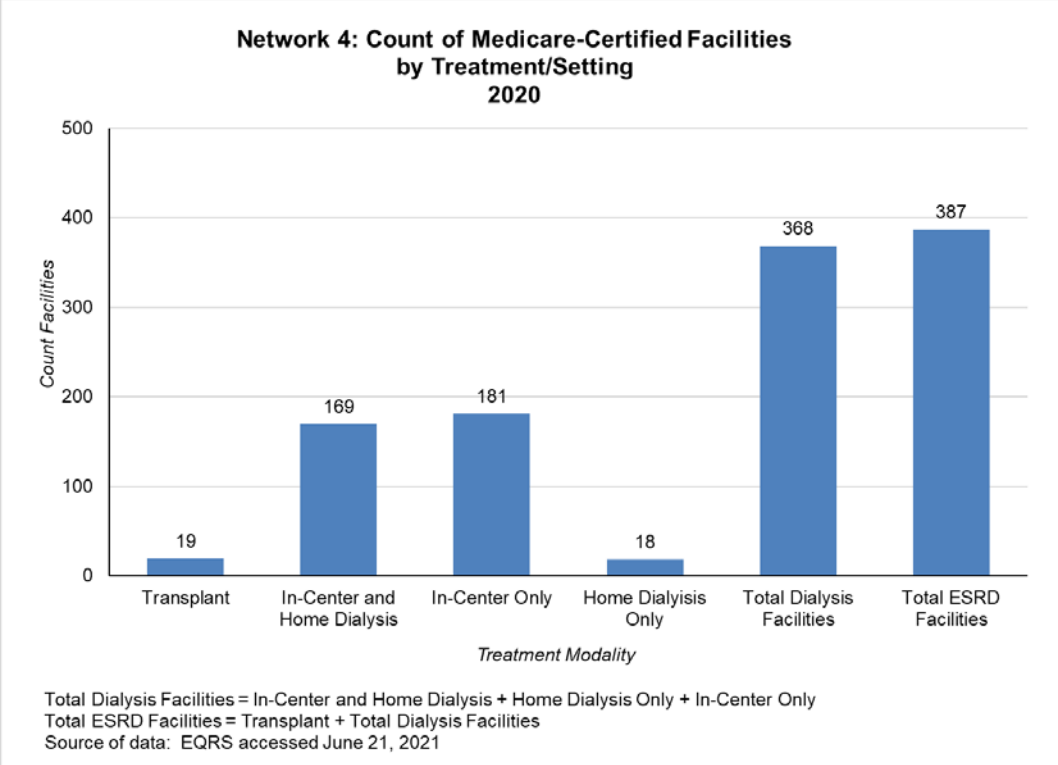


Figure 4 - Percent of National Prevalent Dialysis Patients in each Network Service Area as of 12/31/2020

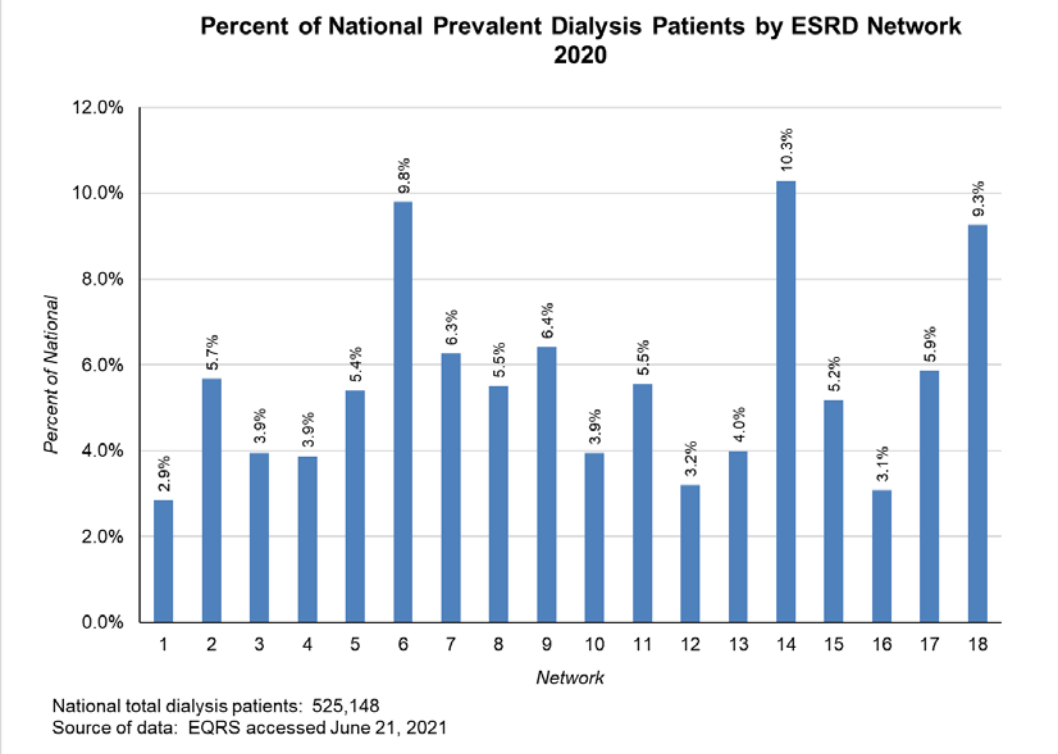


Figure 5 - Percent of Incident Dialysis Patients in each Network Service Area as of 12/31/2020

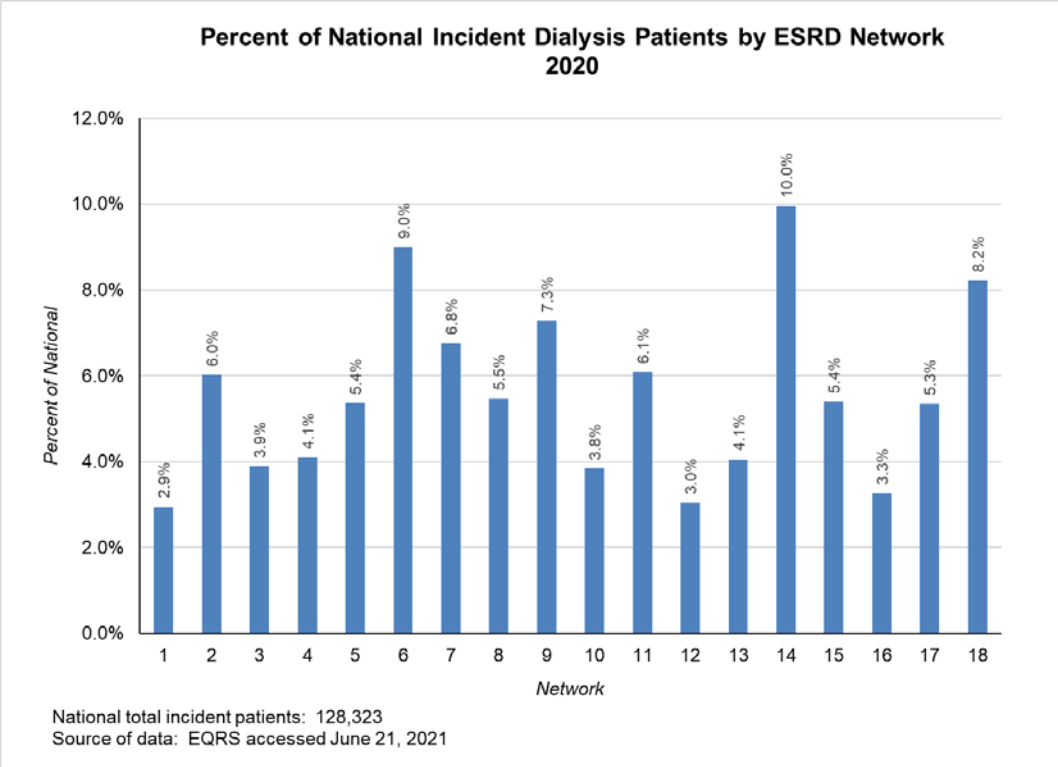


Figure 6 - Percent of Medicare-Certified Dialysis Facilities in each Network Service Area as of 12/31/2020

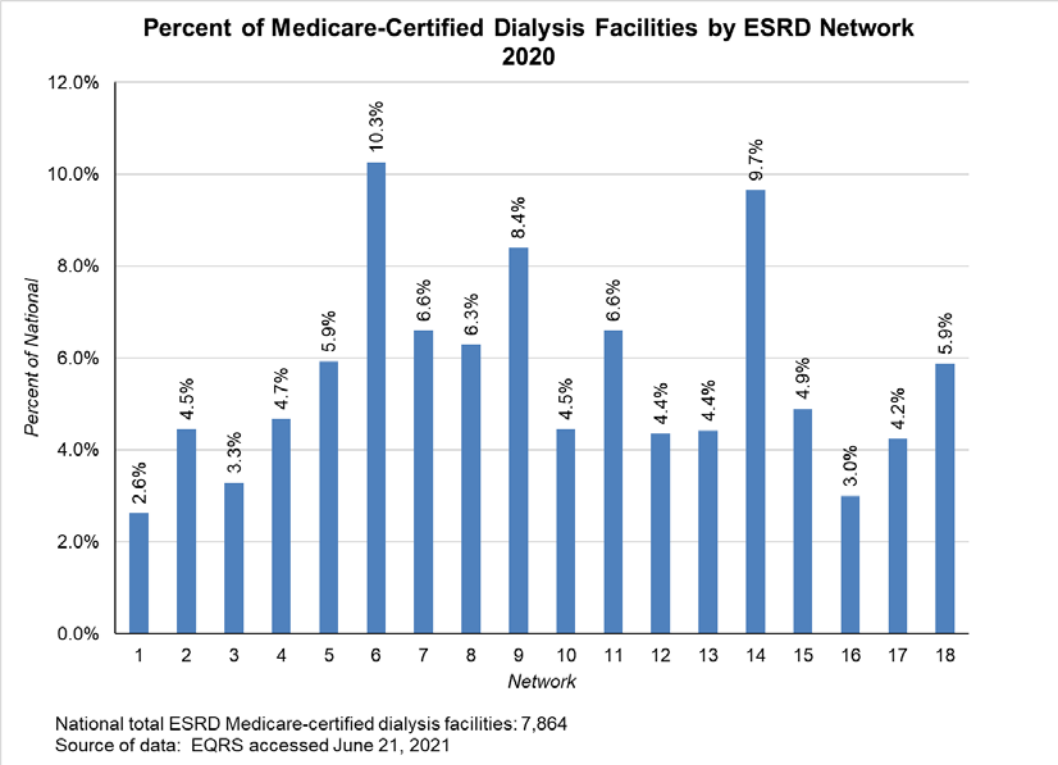


Figure 7 - Percent of National Home Hemodialysis and Peritoneal Dialysis Patients in each Network Service Area as of 12/31/2020

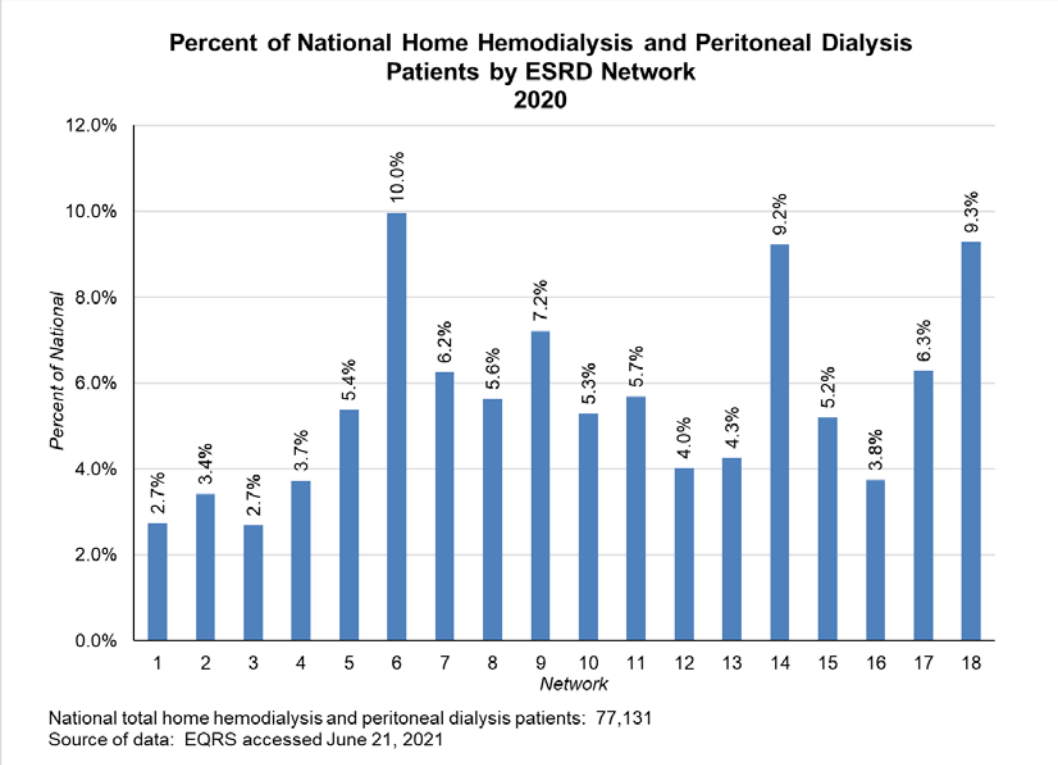


Figure 8 - Percent of National Total Transplants Performed in Each Network Service Area as of 12/31/2020

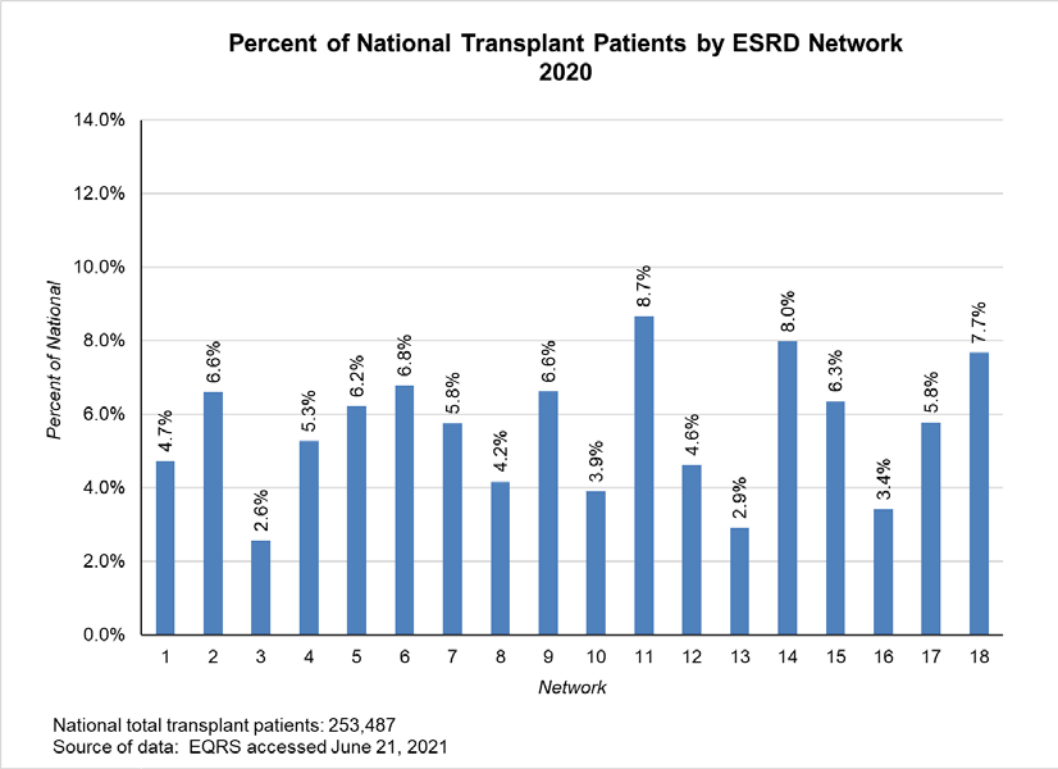
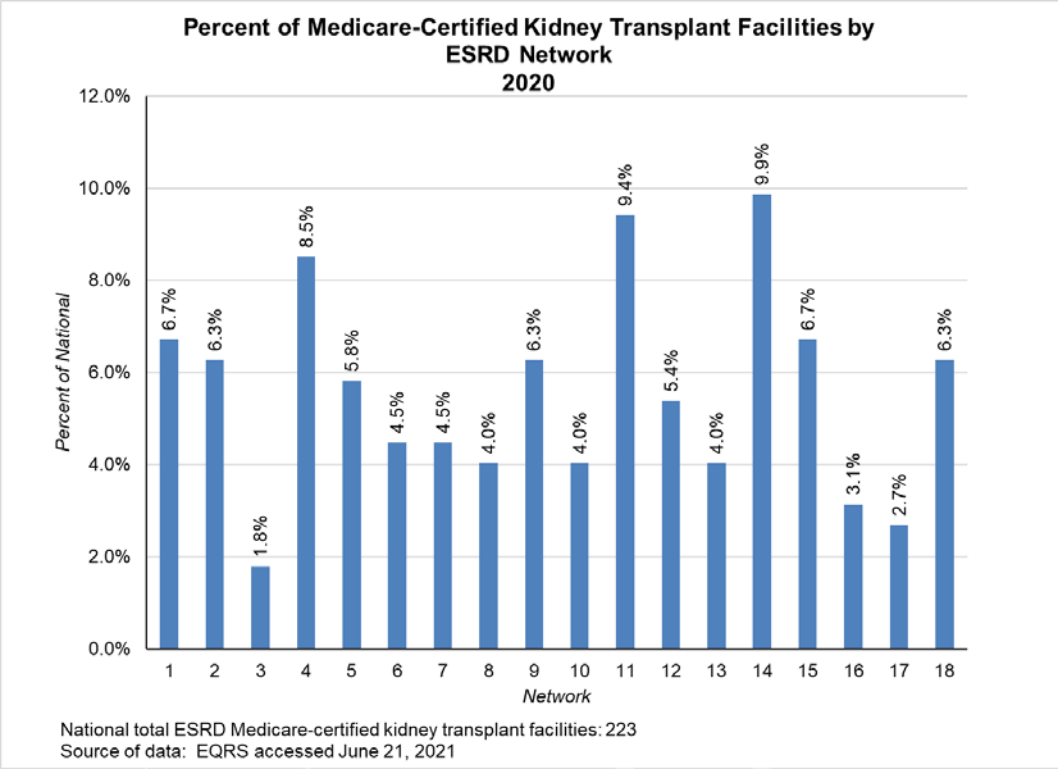


Figure 9 - Percent of Medicare-Certified Kidney Transplant Facilities in Each Network Service Area as of 12/31/2020

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ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA

The ESRD Network contract indicates the following in Section **C.3.22.A. Evaluate and Resolve Grievances**: *"The Network's case review responsibilities shall include taking all necessary steps to evaluate and resolve grievances filed by, or on behalf of, one or more ESRD patients. A grievance is defined as a formal or informal written or verbal complaint that is made to any member of the dialysis or transplant center staff by a patient, or the patient's representative, regarding the patient's care or treatment."*

We ensure that patients are aware of their rights to file a grievance at their dialysis or transplant facility as well as with us.

We employ a trained social worker and nurses who are adept at managing patient and/or family members' grievances. Based on the many years of experience our staff have as direct care practitioners in the dialysis and transplant settings, we have an understanding of the dynamics of these settings. This experience allows us to investigate the grievances received with the skills necessary to ensure a fair and patient-centered approach to the investigation. We received 4 calls during which we could provide immediate advocacy in 2020. These cases included treatment related/quality of care issues, staff related issues, and physical environment concerns.

We also investigated 19 Clinical Quality of Care cases filed by patients in 2020. These cases required the review of medical records by a Registered Nurse. Each case resulted in recommendations for the staff with regard to appropriate care of the patients. These cases were also teaching opportunities for the staff that ultimately impacted the well-being of all patients at these two facilities.

We are also responsible for addressing Access to Care cases with our providers. In 2020 we had 45 contacts from dialysis providers regarding access to care issues that included Involuntary Discharge (IVD) cases, Involuntary Transfer (IVT) cases, as well as patients At Risk for IVD/IVT.

We are also responsible for addressing concerns identified by staff at dialysis facilities involving patients who have exhibited behaviors that are difficult to manage. These patients may eventually end up at risk for IVD/IVT, and our early intervention helps the facility staff find alternatives that help reduce the need for discharges. In 2020, we fielded 54 Facility Concerns.

The goal of each interaction with patients and staff is to ensure the care provided to and received by patients meets the ESRD Conditions for Coverage. This care cannot be provided if patients are involuntarily discharged from their dialysis provider. Every interaction with facility staff related to problem patient behavior is focused on actions that the staff can take to help patients alter their behaviors to ensure they can remain in their current facility.

Figure 11 - Percent of Grievance and Non-Grievances by Case Type (December 2019-December 2020)

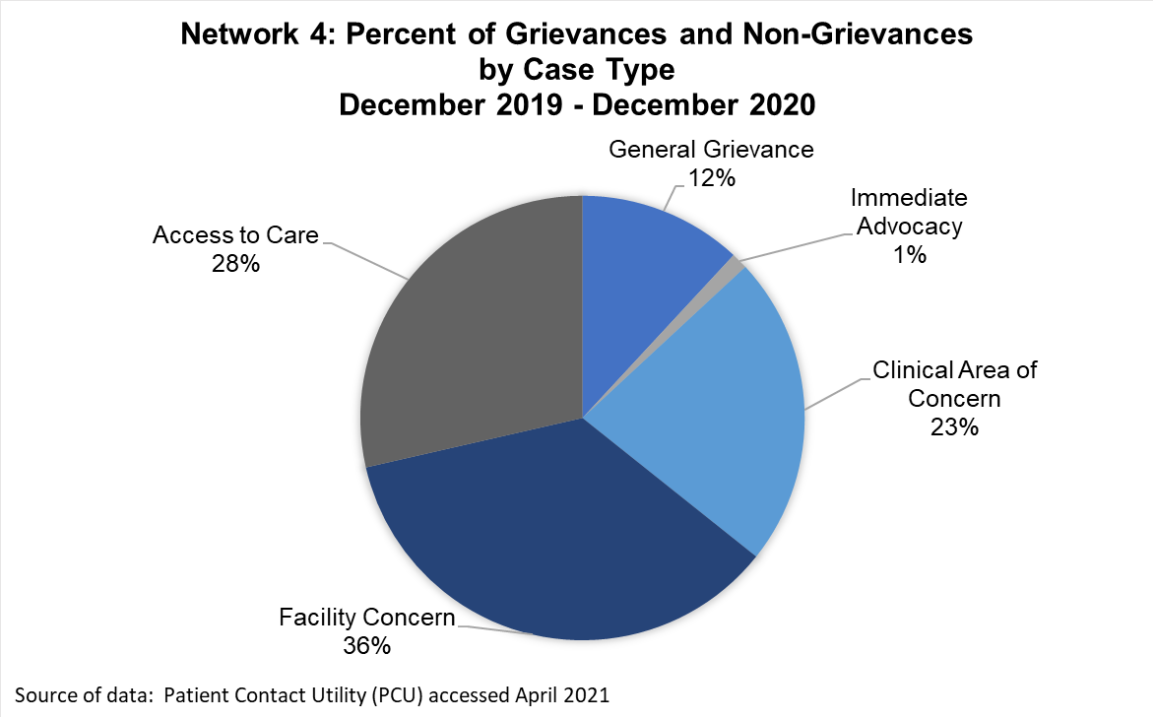
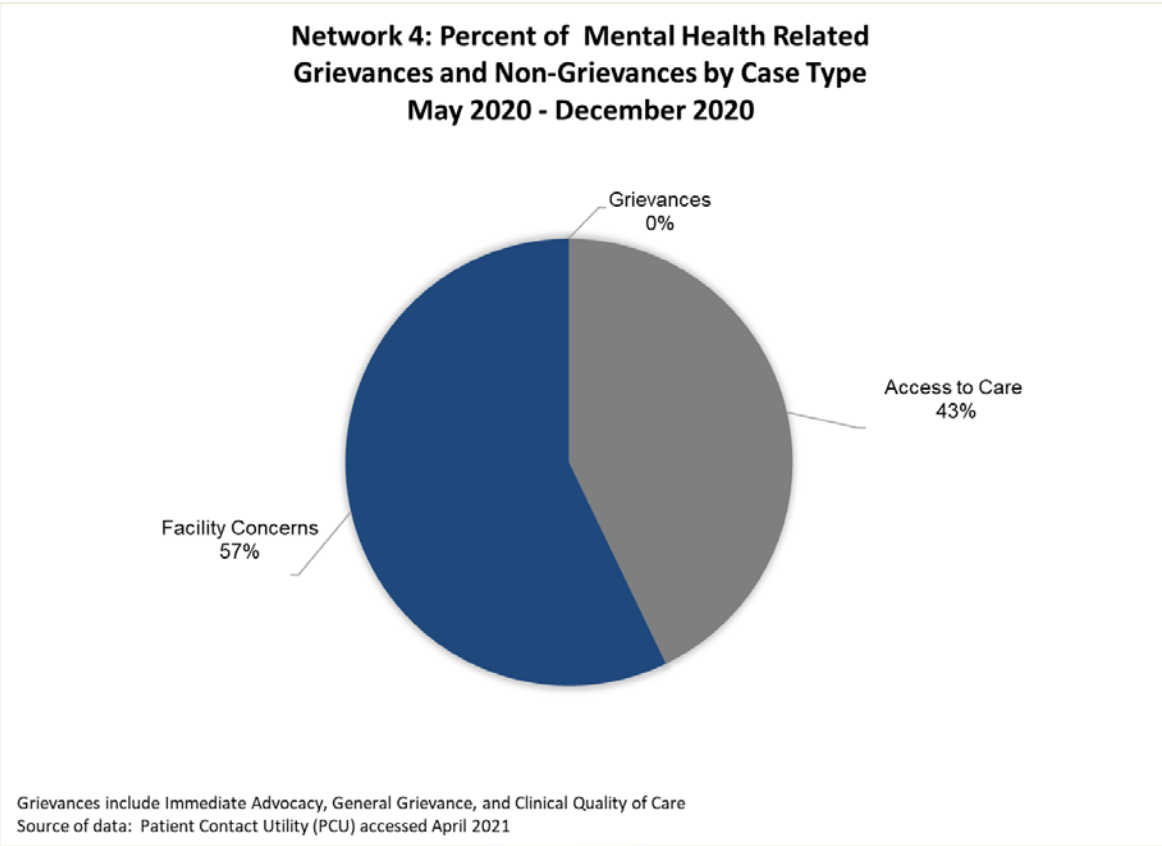


Figure 12 - Percent of Mental Health Related Grievances and Non-Grievances by Case Type (May 2020-December 2020)

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ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA

Long Term Catheter Quality Improvement Activity

Goal: Reduce rates of long term catheters in the network service area by at least 0.25% for patients receiving dialysis through a catheter for more than 90 consecutive days (called long term catheters or LTC).

Results: Goal was suspended due to the COVID-19 pandemic although 111 clinics did achieve their individual goals.

Interventions

- Site visits to review baseline data and share strategies to address barriers
- 1:1 coaching calls targeted facilities to discuss self-identified process and/or patient barriers followed by assisting with development of a quality improvement (QI) plan using the Institute of Healthcare Improvement's (IHI) Model for Improvement: Plan-Do-Study-Act (PDSA) cycle
- Identified successful and unsuccessful practices during coaching calls which were distributed to the network service area clinics along with our recommendations.
- Medical Directors were sent a letter of notification of participation in the QIA, which included a summary of the project, baseline data, clinic goal and an 'ask' for their active engagement in this QIA. Feedback on the use of this letter was positive.
- We collaborated with Networks 10 and 12 to update and distributed the Ease the Ouch patient brochure to help decrease the fear of and actual pain associated with inserting a dialysis needle

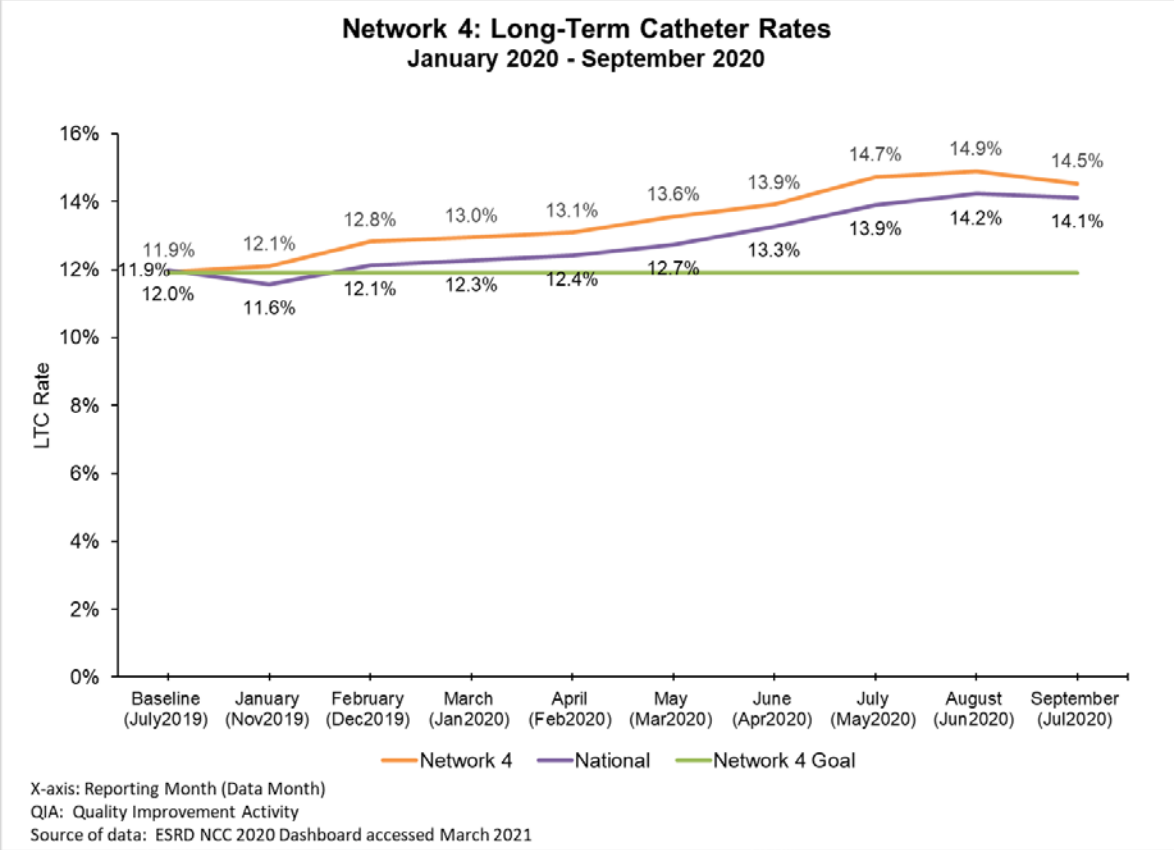
Identified Best Practices

- It was not possible to conduct an evaluation to identify network best practices due to the need for us to focus our attention on supporting clinics during the pandemic and eliminate nonessential correspondence and tasks.
- Successful practices of the clinics included the use of physician extenders to manage vascular access (VA) plans, use of visual tools such as white boards and bulletin boards which are easily accessible to all VA team members, nursing leaders meet with new surgeons, setting up patient's surgical consult prior to hospital discharge or on day of first dialysis treatment and using transitional care units which are successful at removing catheters prior to the 90th day after insertion.

Identified Barriers

- Network Barrier – COVID-19 pandemic
- Patient Barriers - patient or family refusal, missed appointments
- Clinic Barriers - Limited availability of surgeons; extended maturation times, some due to a specific surgical procedure which requires two separate surgeries before the VA can be utilized vs. the traditional one step procedure.

Figure 13 – Long Term Catheter Rates (January 2020-September 2020)



Blood-Stream Infection Quality Improvement Activity

Goal of QIA: Achieve a 20% or greater relative reduction in the aggregate Blood-Stream Infection (BSI) rate from the baseline period (January-June 2019) by the end of June 2020 in 73 target facilities with the highest excess infection rates in 2019.

Results: As shown in Figure 14, at the conclusion of this project the facilities exceeded the goal by experiencing 58 fewer infections compared to the goal of 40 fewer infections. Additionally, the percentage of facility practices aligning with all nine CDC Core Interventions (CI) for Bloodstream Infections increased from 47% to 61% by September 30, 2020. There was also improved alignment with each CI. In 2019, 55.6% of all Network services area facilities had access to a hospital electronic medical record (EMR), a regional or national health information exchange (HIE) or an evidenced based policy or process in place to easily obtain patient medical records. The CDC believes easy access to records will allow facilities to capture infections identified during a hospitalization, report results to NHSN and provide appropriate care to the patient in a more timely fashion. Due to the COVID-19 pandemic, only 3 additional facilities obtained this level of access in 2020 prior to the CMS suspension of this goal. As shown in Figure 15, we were able to determine the infection prevention patient education provided during the project was effective in increasing knowledge and changing behaviors.

Interventions

- Implementation of as many of the CIs, as allowed by each clinic's organizational policies, using the CDC Prevention Process Measures, a root cause analysis and the IHI Model for Improvement - PDSA cycle.
- Promoting patient education and engagement using a "For Your Safety" infection prevention bulletin board and optional contest. Facilities were encouraged to involve patients in the design of the boards. The focus was what the patients can do to protect themselves from infection and/or what the staff do to protect patients from infection. Eight-two percent of patients surveyed replied 'true' to the question "Did you learned something new after reading the patient education materials on their clinic's For Your Safety infection prevention bulletin board. Patient education on infection prevention using this strategy was successfully converted in to a change of practice for 87% if patients surveyed
- End of Day Clinic Clean and Disinfection Audit was developed and used in the 2019 QIA and updated to meet new cleaning standards evolving from the COVID-19 pandemic. The updates included the appropriate use of the United States Environmental Protection Agency (EPA)-approved product that is active against SARS-CoV-2, cleaning of high touch areas such as ledges and half walls and links to the EPA website for disinfectants and CDC Cleaning and Disinfection website.
- Medical Directors were sent a letter of notification of participation in the QIA that included a summary of the project, baseline data, clinic goal and an 'ask' for their active engagement.
- Began development of a patient education brochure outlining how patients with CVC can care for their catheter when they are away from the dialysis unit to address identified gap in implementation of CI #5 Patient Education/Engagement

Identified Best Practices

No new best practices were identified; however, best practices from the 2019 QIA underwent PDSA cycles and were adapted, then implemented in the 2020 QIA in hopes of increasing the impact on BSI reduction.

- Patient feedback on staffs' performance of hand hygiene – Clinic managers obtained verbal feedback of hand hygiene practices through direct questioning of patients. This method allowed for many more patients to provide timely feedback

- Collecting patient observations on healthcare staffs' hand hygiene practices using a targeted questioning approach by the facility administrator in addition to patients performing hand hygiene audits. The questions prompted only general comments about adherence such as evaluating the nurses' performance of hand hygiene after removing gloves on a scale of 1 to 5 stars. Since the implementation of this successful intervention did not begin until the latter part of the remeasurement period in the 2019 QIA, it was implemented at the beginning of the 2020 QIA in hopes to expand its impact on increasing the number of patients engaged in their care. The baseline rate of compliance with CI#5 in 2019 was 49% and in 2020 it was 83%. The goal to improve on the rate of compliance for the 2020 QIA would be challenging given the elevated baseline rate. However, with the use of this intervention we were able to increase the compliance rate to 94% between January and March, prior to the pandemic.
- Core Interventions Self-Assessment tool – This tool was developed and used in 2019 and implemented again in 2020. It was used to educate clinics on the expectations of how to fully implement each CI and identify areas for improvement. Improvement areas were addressed using the IHI PDSA cycle.
- Infection Control Assessment & Response (ICAR) survey – We again collaborated with the Philadelphia Department of Public Health and the Pennsylvania Department of Health /Epidemiology Division to provide an opportunity to select facilities to receive a voluntary ICAR. This could not be implemented due to the COVD-19 pandemic.

Identified Barriers

- Due to the Public Health Emergency CMS made NHSN reporting optional for encounters occurring October 1, 2019 through June 30, 2020, which includes the QIA remeasurement period.
- Some dialysis organizations do not permit the use of an antimicrobial ointment with each CVC dressing change which is part of Core Intervention #9
- Some Medical Directors are reluctant to permit patients to touch or care for their CVC dressing when they are away from the clinic, which impedes compliance with CI#5. Additionally, some facilities did not have any written materials to provide patients with guidance.

Figure 14 – Reduction in Bloodstream Infections Long Term Catheter Rates (January 2020-June 2020)

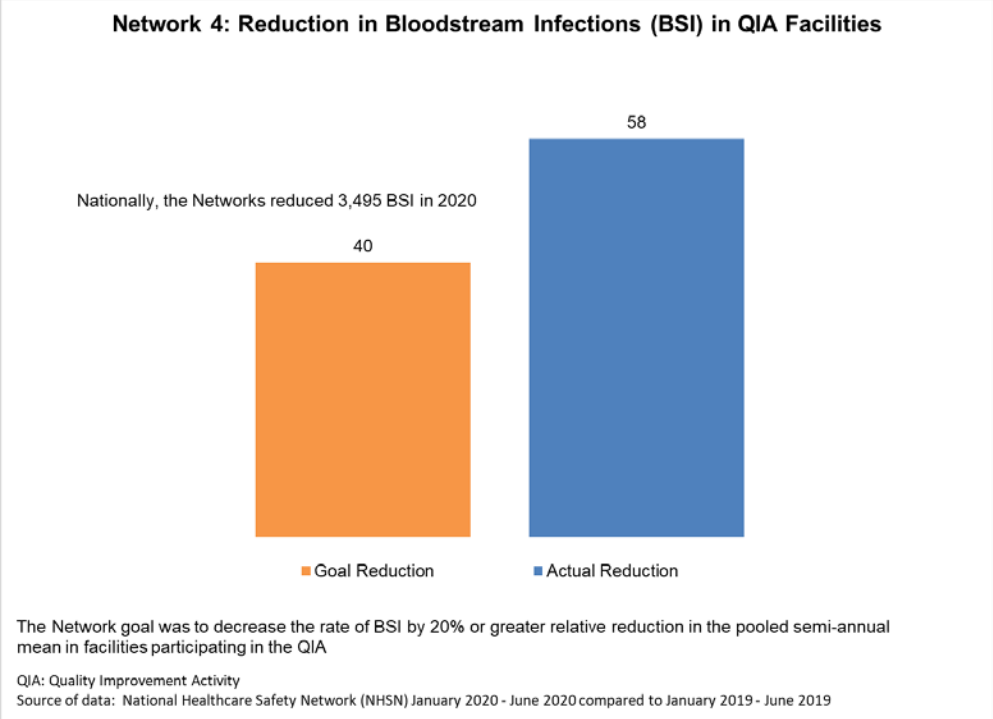
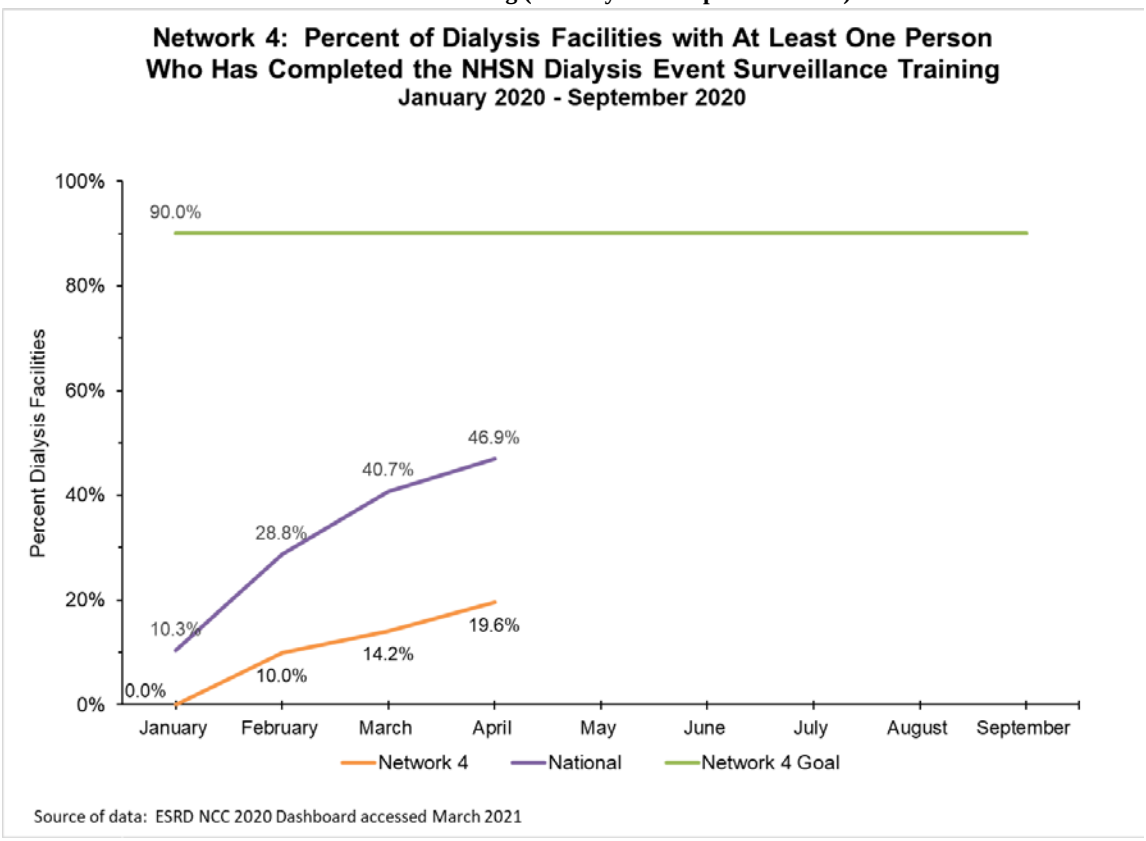


Figure 15 – Percent of Dialysis Facilities with At Least One Person Who has Completed the NHSN Dialysis Event Surveillance Training (January 2020-September 2020)



Transplant Waitlist Quality Improvement Activity

Due to the COVID-19 pandemic limiting provider staffing and procedures, along with contract goal adjustments, we worked toward the goals of this quality improvement activity, but were not evaluated on results.

Goal of QIA: Using the ABC™ model, we planned to increase the rate of patients added to the transplant waiting list in the Network service area by at least 1.25% by September 30, 2020 by working with incident patients, prevalent patients, and dialysis facilities. The goal was to add an additional 900 patients to the transplant waiting list in this project period.

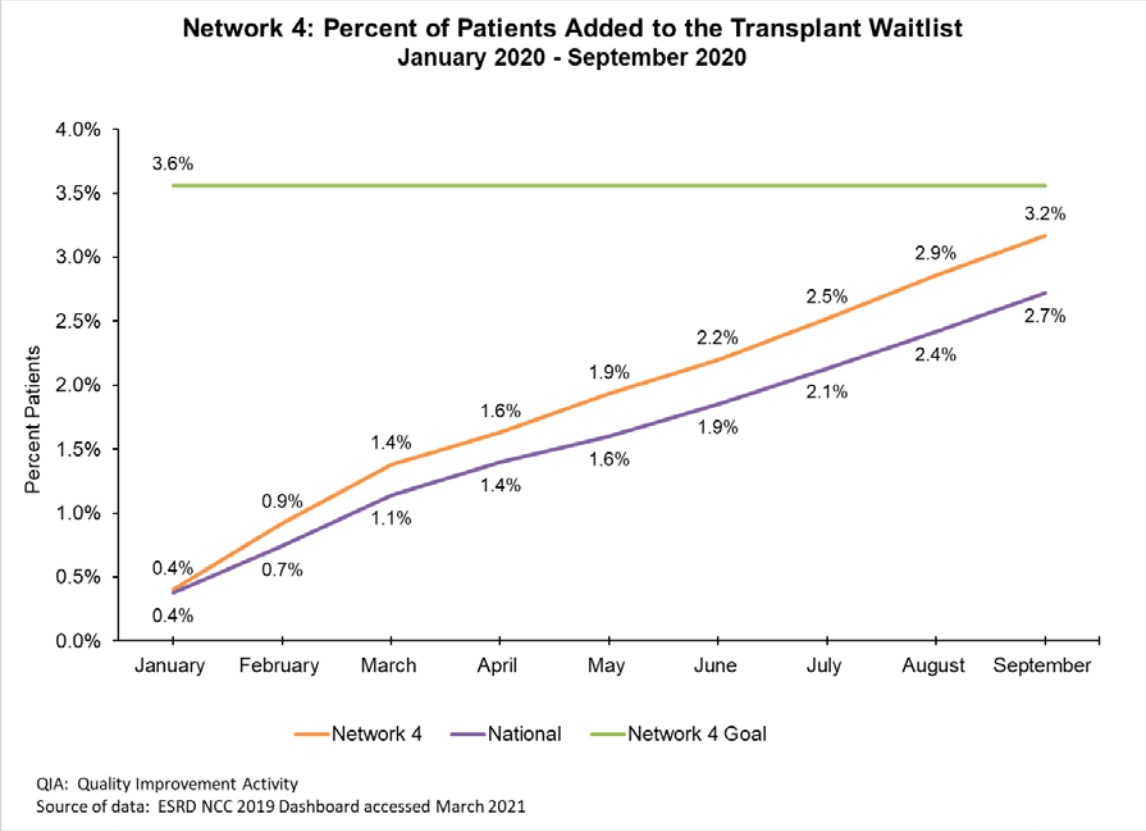
Results: Transplant evaluations and surgeries along with other elective surgeries were greatly impacted during the COVID-19 pandemic, especially during the first wave in the hardest hit areas as healthcare providers learned how to deal with the pandemic. As shown in the following figure, providers in the Network 4 service area were achieving the first three months' interim goals. However, beginning in April 2020 there was a decline in the number of patients being added to a transplant waitlist as a result of difficulty accessing in-person transplant evaluations, and a pause in living donor and most deceased kidney donor transplant surgeries because of the pandemic. Nonetheless, the overall kidney transplant waitlist rate continued to increase, albeit at a slower rate.

Interventions: We planned a robust improvement methodology that included using improvement strategies from the Institute for Healthcare (IHI) Model for Improvement, including the use of root cause analysis (RCA), development of a facility-specific quality improvement plan, and use of Plan-Do-Study-Act (PDSA) cycle(s) to test change. As targeted facilities submitted their monthly progress reports, facilities were expected to make changes to their proposed interventions if necessary until the completion of the project. Additionally, we deployed a multi-pronged approach that included comparative feedback reports, encouragement of process changes at the dialysis unit, and development of transplantation educational materials geared toward identified barriers. Furthermore, plans were underway to continue the best practice of peer-to-peer mentoring by offering our patient advocates to assist in educational lobby days and patient-to-patient dialogue. To address the communication gap reported by dialysis facilities and transplant centers to track patients, we continued to disseminate patient level report to both entities. We developed the report during the 2019 project and received positive feedback. The patient level report allowed providers to identify patients' active/inactive wait list status and removal reasons. Transplant centers used their reports to identify patients' dialysis facility locations and contact numbers.

Identified Best Practices: The COVID-19 pandemic affected everyone, bringing many challenges for patients to be waitlisted. Even so, providers were encouraged to continue to educate patients on the kidney transplant option and refer patients as transplant centers were utilizing telehealth to provide some portion of education for the evaluation process. During the pandemic, telehealth emerged as the mode of access to healthcare for those who were not able to been seen in-person. As a part of transplant education, we introduced the National Coordinating Center's (NCC's) Transplant Change Package and selected participating facilities to tests change ideas from the change package. The change package implementation is still ongoing and results will be forthcoming in the next annual report.

Identified Barriers: In addition to the main barrier–the COVID-19 pandemic–other top barriers identified by the project facilities for getting patients on the transplant waiting list included the lack of follow up with appointments, the burdensome process of transplant evaluation, and educational knowledge gap for both facility staff and patients

Figure 16 – Percent of Patients Added to the Transplant Waitlist, Network, National and Goal



QIA: Quality Improvement Activity
Source of data: ESRD NCC 2019 Dashboard accessed March 2021

Home Therapy Quality Improvement Activity

Due to the COVID-19 pandemic limiting provider staffing and procedures, along with contract goal adjustments, we worked toward the goals of this quality improvement activity, but were not evaluated on results.

Goal of QIA: Using the ABC^{TM} model, we planned to increase the rate of patients that begin dialyzing at home in the Network service area by at least 2.5% by September 30, 2020 by working with incident patients, prevalent patients, and dialysis facilities. The goal was to attain 1,291 home dialysis initiations.

Results: Providers were challenged during the COVID-19 pandemic, especially during the first wave in the hardest hit areas as healthcare providers learned how to deal with the pandemic. Regardless (as shown in Figure 17), the facilities in the project exceeded CMS expectation. There were a total of 1,304 home dialysis initiations at the end of the project period. In addition, 90.6% (164/181) facilities reported the ability to conduct telemedicine and 91.46% (150/164) facilities with home dialysis patients reported utilizing telehealth.

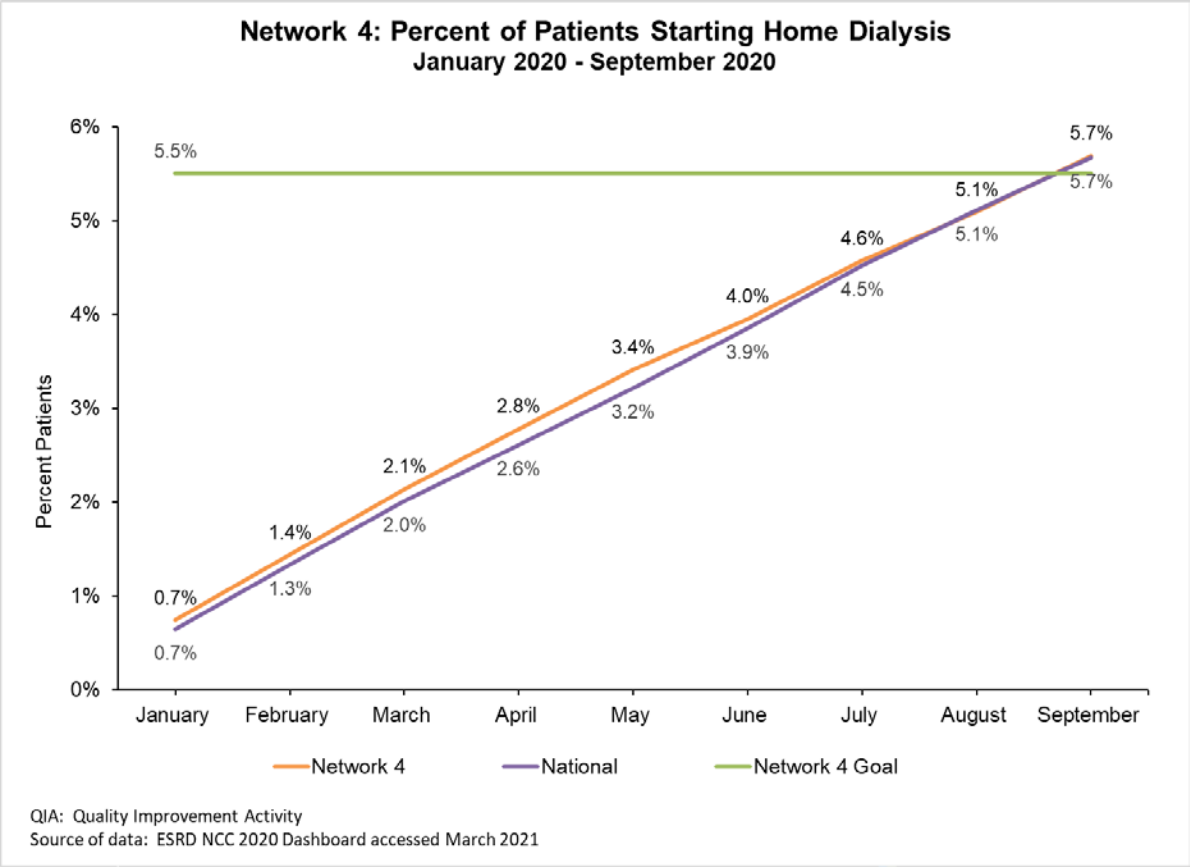
Activities to move 70% of Home Facilities reporting ability to conduct telemedicine

Interventions: Improvement methods used for this QIA centered primarily on the use of the Institute for Healthcare (IHI) Model for Improvement and included the use of root cause analysis (RCA), development of a facility-specific quality improvement plan, and use of Plan-Do-Study-Act (PDSA) cycle(s) to test change. As targeted facilities submitted their monthly progress report, facilities were expected to make changes to their proposed interventions if necessary until the completion of the project. Additionally, we planned a multi-pronged approach that included comparative feedback reports, encouragement of process changes at the dialysis unit, and development of home dialysis educational materials geared toward identified barriers. We encouraged the use of telehealth to support home dialysis patients, and emphasis on home dialysis took on a new level because of the decrease exposure to COVID.

Identified Best Practices: The COVID-19 pandemic affected everyone, bringing many challenges for provider to educate patients on how to reduce the risk of exposure. Therefore, providers were encouraged to educate patients on home modality option because it decreases the need to travel to and from the in-center facility. During the pandemic, telehealth was especially beneficial to home dialysis patients. As a part of home dialysis education, we introduced the National Coordinating Center (NCC) Home Dialysis Change Package and selected participating facilities to tests change ideas from the change package. The change package implementation is still ongoing and results will be forthcoming in the next annual report.

Identified Barriers: In addition to the main barrier–the COVID-19 pandemic–other top barriers for getting patients to change to a home modality included patients' satisfaction with in-center hemodialysis, lack of home support system, and fear.

Figure 17 – Percent of Patients Who Begin Dialyzing at Home, Network, National and Goal



QIA: Quality Improvement Activity
Source of data: ESRD NCC 2020 Dashboard accessed March 2021

Population Health Focus Pilot Project Quality Improvement Activity

Due to the COVID-19 pandemic the PHFPQ quality improvement activity was suspended on April 30, 2020 and not evaluated on outcomes.

Background and Significance

In 1972, Congress established the Medicare End Stage Renal Disease (ESRD) program with the "expectation that the payment for dialysis would return patient to the work force as taxpaying citizens." Since that time, there has been tremendous grown in the ESRD patient population as well as a change in demographics, but the initial expectation of returning patients back to work signifying a move from "disability to ability," has been stagnate.

According to a 2017 study conducted by DaVita Clinical Research, employment among incident patients on dialysis was associated with better clinical and quality of life outcomes compared to unemployment. Despite the study's findings, many patients decide to leave and not re-enter the workforce after initiating dialysis most frequently citing barriers to include fatigue, depression, and the assumption and perception, by patients and employers alike, that dialysis dependence renders an individual unemployable. This is particularly true for a specific subset of the dialysis patient population, including women, patients with congestive heart failure, cardiovascular disease, cancer, and other chronic illnesses, and those who identify as Hispanic or non-white. Among patients identified as being most likely to remain in the workforce in the same capacity as they had in the six months leading to dialysis initiation were patients with 1) fewer comorbidities; 2) those who chose peritoneal dialysis for their first treatment; 3) white men ages 30 to 49 years; and, 4) those with employer-sponsored health insurance.

Goals and Outcomes

- Increase VR referrals by 50%
- Demonstrate at least 1% of denominator population receiving services
- Ensure at least 95% of patients are screened for interest in VR services
- Demonstrate referral of at least 10 eligible patients age 55-64

The project—*Access, Refer, Connect (ARC)*—launched in January 2020 with the first intervention being implemented on February 3, 2020. Outcomes are available in Figure X, X, and X.

Identified Barriers

Barriers to achieving the goals of this QIA were identified by facility-level root cause analyses. The most frequently cited barriers were patient-related:

1. Fear of losing benefits
2. Fear of returning to work
3. Lack of transportation

In addition to the abovementioned goals, the project suspension greatly impacted facilities' ability to achieve the goals outlined in this QIA.

Figure 18 – Percent of Patients Referred to Support Services

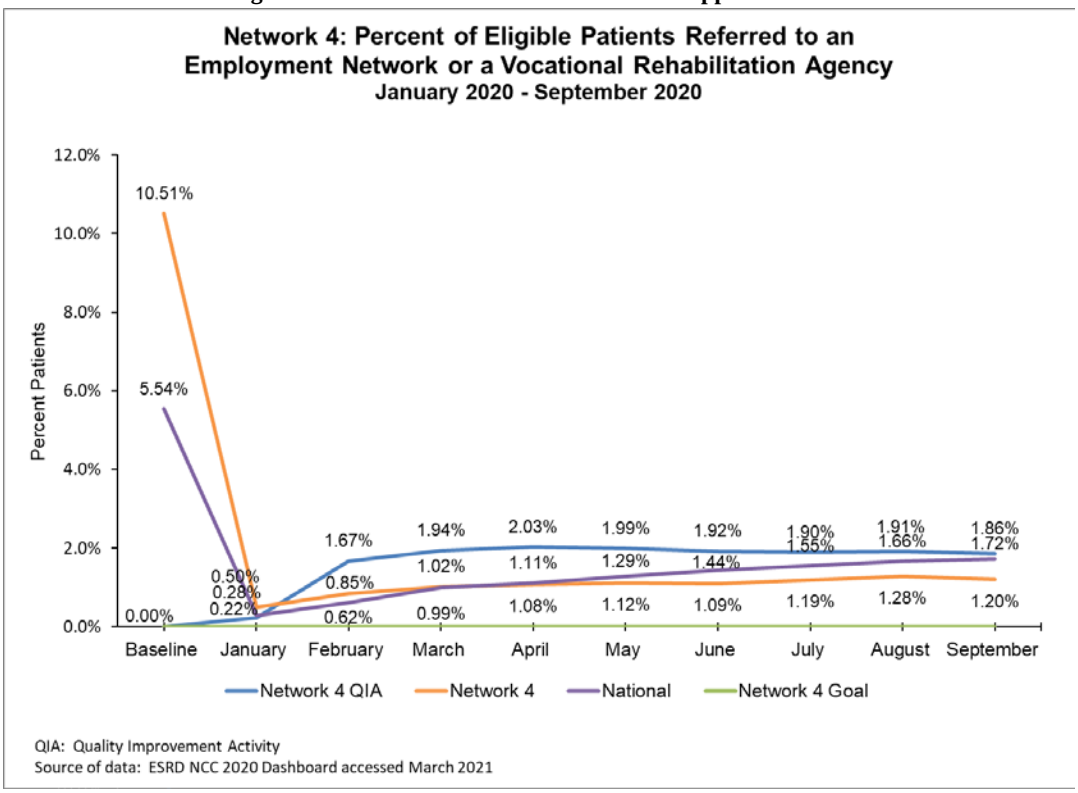
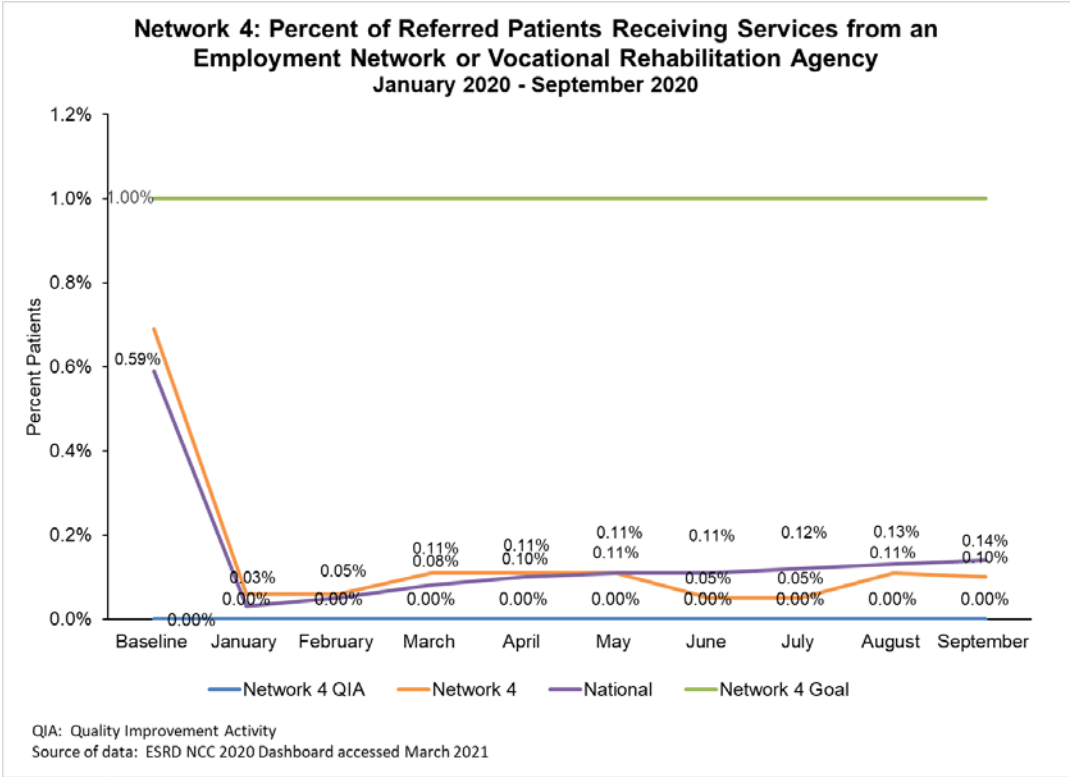
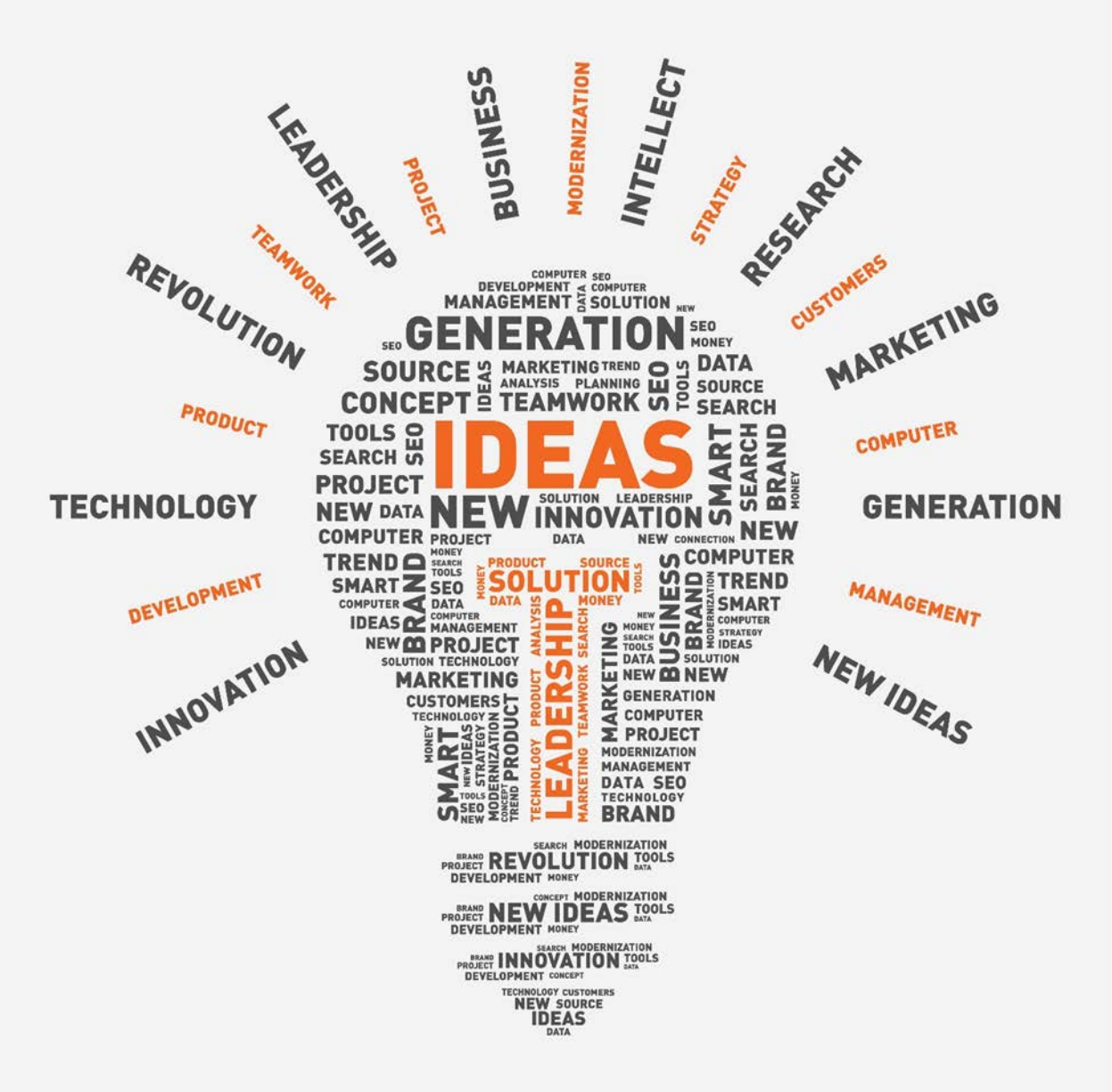


Figure 19 – Percent of Patients Receiving Services




LEADERSHIP
PROJECT
BUSINESS
MODERNIZATION
INTELLECT
STRATEGY
RESEARCH
TEAMWORK
REVOLUTION
CUSTOMERS
MARKETING
PRODUCT
COMPUTER
TECHNOLOGY
GENERATION
DEVELOPMENT
MANAGEMENT
INNOVATION
NEW IDEAS
GENERATION
IDEAS
NEW
LEADERSHIP
SOLUTION
BRAND
MARKETING
REVOLUTION
NEW IDEAS
INNOVATION

ESRD NETWORK RECOMMENDATIONS

Facilities that Consistently Failed to Cooperate with Network Goals

All facilities in the Network 4 geographic area cooperated fully with Network goals and participated in our quality improvement interventions when requested.

Recommendations for Sanctions

We did not recommend sanctions for any facilities in 2020.

Recommendations to CMS for Additional Services or Facilities

We did not recommend any additional services or facilities in 2020. The facilities and services available to patients in the Network 4 geographic area are well distributed and are readily accessible to patients.


first
infrastructure
contingency
environment
aid
continuity
public safety
ambulance
training
communications
earthquake
damage
critical
management
patient
mitigation
injury
preparedness
healthcare
plan
safety
fire
agency
planning
warning
service
help
survival
supplies
team
emergency room
medical
urgent
danger
disaster
protection
kit
evacuation
stretcher
paramedic
business
alarm
medic
safe
jeopardy
resilience
incident
equipment
disease
emergency
urgency
threat
natural disaster
information
property
natural
nurse
crisis
doctor
government
recovery
health
situation
environmental
risk management
public
response
rescue
hospital
security
room
intervention
operations
medicine
life
accident
risk
education
loss
system

ESRD NETWORK COVID-19 EMERGENCY PREPAREDNESS INTERVENTION

The Centers for Disease Control and Prevention (CDC) confirmed the first COVID-19 case in the United States on January 20, 2020. By March 11, 2020 the World Health Organization (WHO) characterized this infectious respiratory disease caused by the spread of the SARS-CoV-2 virus as a pandemic. The ESRD stakeholder community, like the broader healthcare industry, has been faced with an unprecedented challenge in the COVID-19 pandemic. According to the CDC, the ESRD status of dialysis patients is a top vulnerability indicative of increased risk for severe illness from COVID-19 (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html). The dialysis providers, ESRD National Coordinating Center (NCC) and the ESRD Networks, federal public health agencies, professional associations, and the KCER program responsible for managing dialysis care during disasters faced a unique call to action and stepped up to respond.

Starting March 5, 2020, we initiated response by providing dialysis centers with technical assistance, educational tools, support and guidance regardless of COVID-19 cases presented at their facility or community. Due to the overwhelming amount of information released on a daily basis by the CDC, WHO, CMS, and other experts, we established the *QIRN4 Weekly: COVID-19 Resources & Memos / Upcoming Webinars / In Case You Missed It* emails. Here we compiled all dialysis & COVID-19 pertinent information and share it with the 362 Pennsylvania and Delaware dialysis providers' medical directors, regional managers, facility administrators, clinic managers, social workers and dietitians. In addition, we created a dedicated webpage to post COVID information for providers and patients (https://www.qualityinsights.org/Coronavirus/Kidneys.aspx), which we continually updated as new guidance, waivers and lessons learned were released.

We utilized the KCER National ESSR weekly reports to conduct analysis of new cases and identify hotspots throughout our Network service area. Our team established a process to contact, one to one via phone call, all facilities who were reporting new and/or increased COVID-19 cases. Via this technical assistance our staff were able to address emerging issues at the dialysis centers, identified if providers were applying interventions equivalent to or more stringent than CDC's recommendations, detect nursing homes/long term care facilities who were experiencing influx of COVID-19 cases, addressed barriers as well as successes, and provided individualized support.

We were active participants in regular calls with the Pennsylvania and Delaware Departments of Health and the Pennsylvania Disability Integration Task Force, which addressed COVID-19 conditions, actions, needs (current and anticipated) and report outs from state and county level agencies.

Amongst all issues presented by the COVID-19 pandemic, transportation was identified as a primary concern during the early stages. Dialysis providers reached out to us reporting suspension of county transportation and paratransit for the disabled. We received reports regarding limited transportation for patients who had been assigned to a COVID-19 cohort dialysis center outside of their county of residence or had to stay in hospital due to transportation companies not accepting them. We assisted dialysis providers by bridging lines of communication with the County Office of Emergency Management (OEM) officials. We made referrals to the Medicaid transportation broker in PA and DE, Logisticare, for any issues related to companies' refusal to transport COVID positive Medicaid patients.

The regularly scheduled KCER calls were an essential vehicle to identify issues and obtain answers from attendees such as CDC, CMS, ASPR, ASN, and dialysis corporate leadership. This allowed us to gather best practices and disseminate them throughout the Network service area.

We continually track and trend all ESRD COVID data at a state and national level and monitor these trends to ensure that there is no suspicious spike up or down, which could be indicative of a reporting anomaly. We also periodically compare the ESRD COVID data to the national "general population" COVID data to see if the trends in our dialysis population is tracking with the national totals. We have shared some of this analysis with KCER, NCC and CMS to identify data points needing investigation and/or to illustrate how the COVID-19 impact on our dialysis population seems to be a microcosm of the national impact.

ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION

Other than activities related to the COVID pandemic described in the prior section, there were no significant emergencies in 2020 that required our intervention or support.

APPENDIX

ACRONYM LIST

This appendix contains a link to a list of acronyms created by the KPAC (Kidney Patient Advisory Council) of the National Forum of ESRD Networks. We are grateful to the KPAC for creating this list of acronyms to assist patients and stakeholders in the readability of this annual report. We appreciate the collaboration of the National Forum of ESRD Networks, especially the KPAC.
https://esrdnetworks.org/education/

Additional Acronym and Glossary Resources

Fresenius Glossary
https://www.freseniuskidneycare.com/glossary
National Center for Biotechnology Information Acronyms and Abbreviations
http://www.ncbi.nlm.nih.gov/books/NBK84563/
Renal Support Network
http://www.rsnhope.org/programs/kidneytimes-library/article-index/renal-acronyms/