



U.S. Virgin Islands

New Jersey

Puerto Rico

ESRD NETWORK 3 2020 ANNUAL REPORT



Quality
Insights

Renal Network 3

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ESRD DEMOGRAPHIC DATA

Quality Insights Renal Network 3 (QIRN3) is pleased to present our 2020 Annual Report. QIRN3 serves dialysis and transplant patients and providers in New Jersey, Puerto Rico, and the US Virgin Islands.

Corporate Affiliation

Quality Insights Renal Network 3 (QIRN3) 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 4 (covering Pennsylvania and Delaware), and QIRN3.

Geographic Description

According to the Census Bureau (<https://data.census.gov/cedsci/>), the 3 geographic areas served by QIRN3 had a combined population of 12.21 million people as of July 1, 2019. While these three areas are geographically small in size, New Jersey (NJ) is the most densely populated state (1,211.3/sq. mi) in the country and, if Puerto Rico (PR) were a state, it would be the second most densely populated (1,040/sq. mi). US territories are often assumed to have small populations, but Puerto Rico had a sizable population (3.2 million) as of July 1, 2019, and had 6,231 patients receiving dialysis as of December 31, 2020. The 6,231 patients receiving dialysis in Puerto Rico was more than the dialysis patient population of 27 states, including large states such as Kentucky, Oklahoma, Colorado and Arizona.

These dense populations create challenges for providing dialysis to patients, as there is a greater than average number of patients per dialysis unit in these areas. According to the 2020 Annual Facility Survey performed by QIRN3, 194 dialysis units in New Jersey treated an average of 66.3 patients in 2020, and 49 dialysis units in PR treated an average of 127.2 patients, compared to an average of 63.7 nationwide. The 4 dialysis units in the US Virgin Islands (USVI) treated an average of 54.5 patients in 2020.

As shown in Figure 1, as of December 31, 2020 there were 18,656 patients receiving treatment in dialysis facilities in the Network 3 service area, and an additional 2,075 patients receiving treatment in their homes. This total of 20,731 patients receiving dialysis, plus an additional 6,514 patients living with a functioning kidney transplant in the Network 3 service area brings the total ESRD patient count for this area to 27,245.

The number of Medicare-Certified ESRD facilities in the Network 3 service area, by treatment modalities offered, is shown in Figure 3. In 2020 there were 4 transplant centers, 138 dialysis centers offering both in-center dialysis and home dialysis support, 111 dialysis centers offering in-center dialysis only, and 9 dialysis centers offering home dialysis support only, for a total of 258 dialysis centers and 262 centers that support ESRD patients. Figures 3 through 7 illustrate the percentage of national totals of patients and facilities that those in the Network 3 service area constitute.

Figure 1- Number of Patients Treated in the Network 3 Service Area as of December 31, 2020 by Treatment Modality

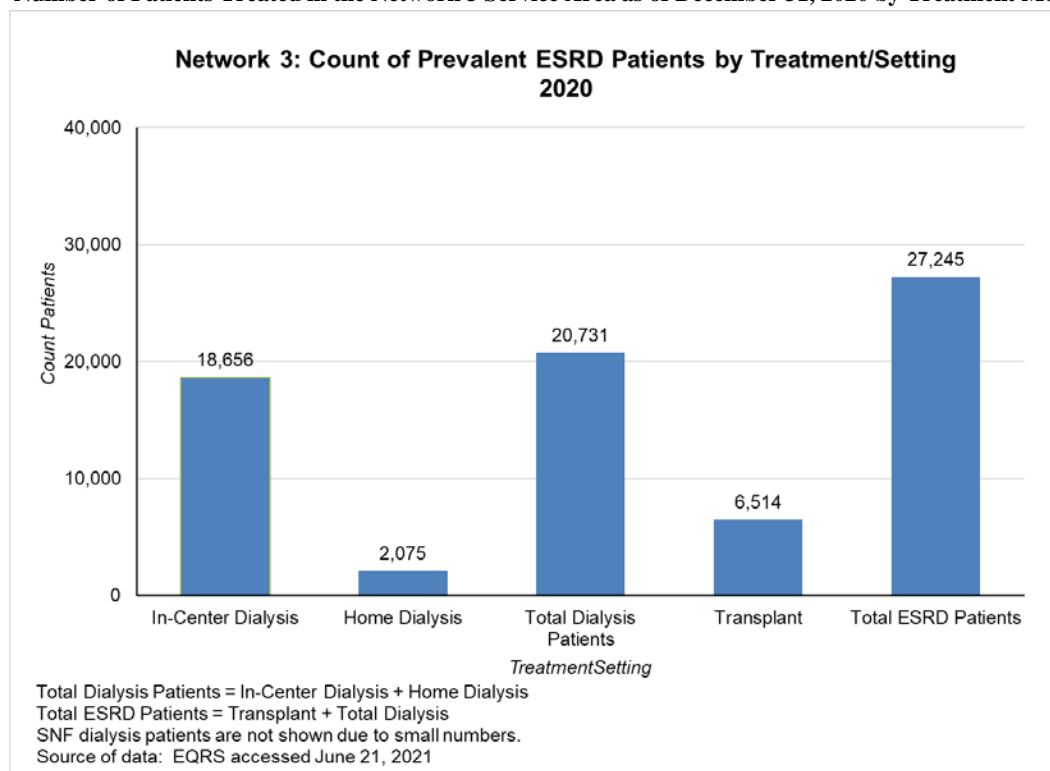


Figure 2- Number of Incident Patients Treated in the Network 3 Service Area for the 2020 calendar year by Treatment Modality

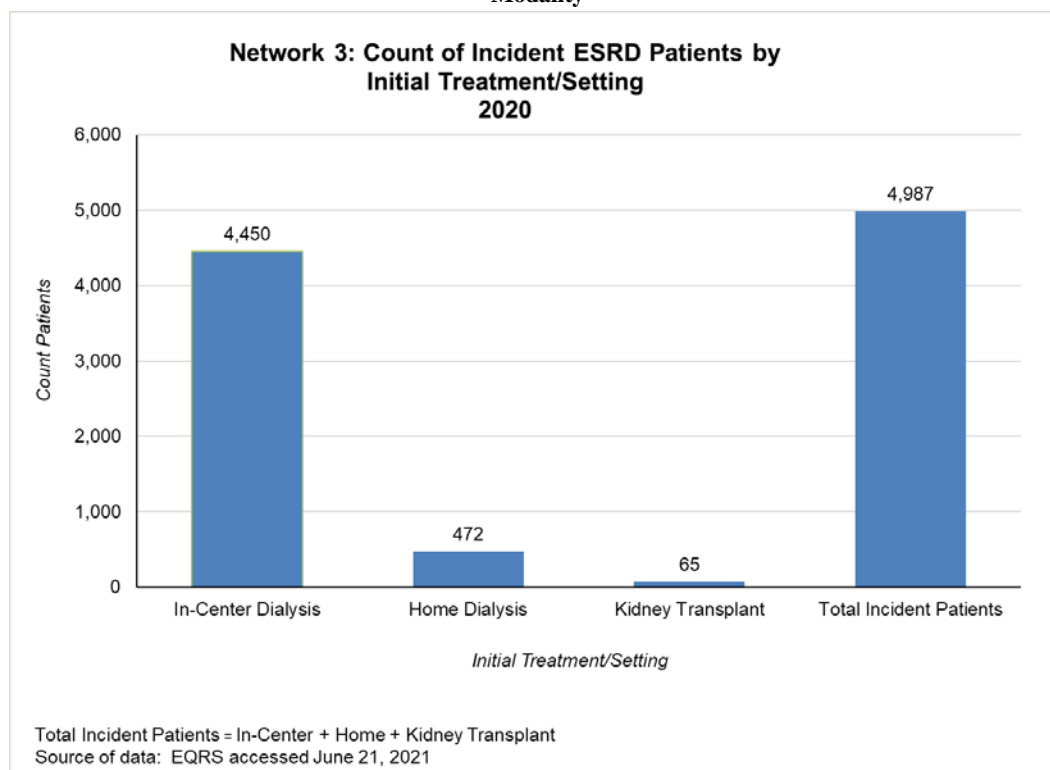


Figure 3 -Number of Medicare-Certified Facilities in the Network 3 Service Area by Modality Offered as of 12/31/2020

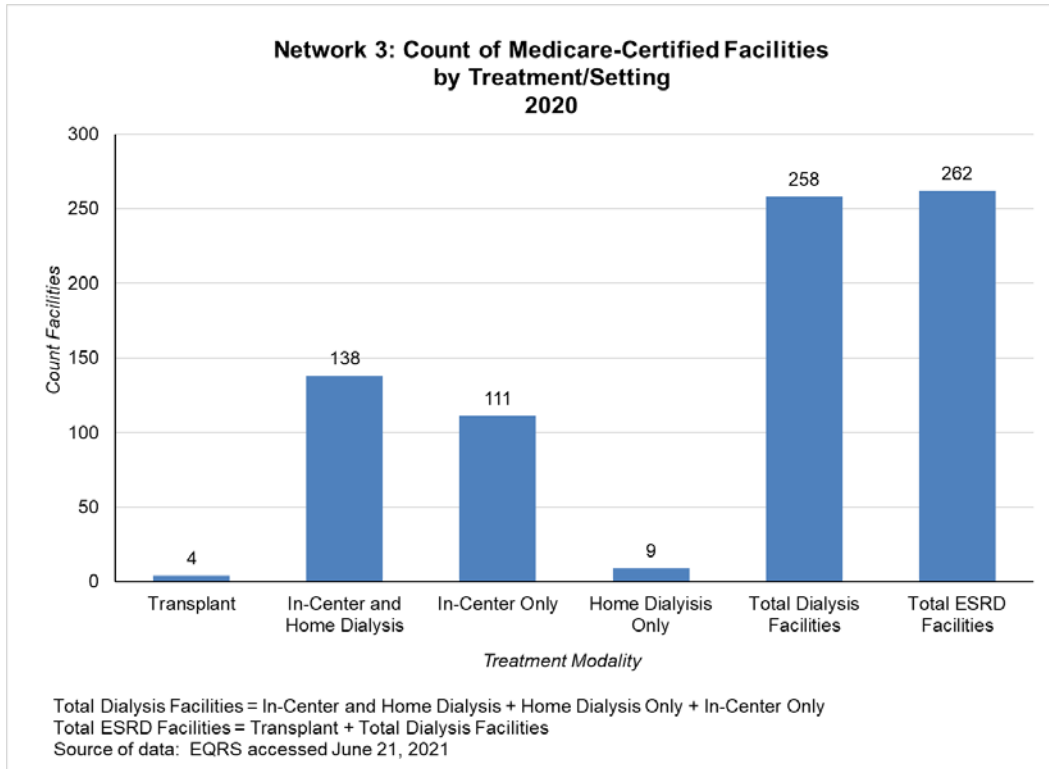


Figure 4 - Percent of National Prevalent Dialysis Patients in each Network Service Area as of 12/31/2020

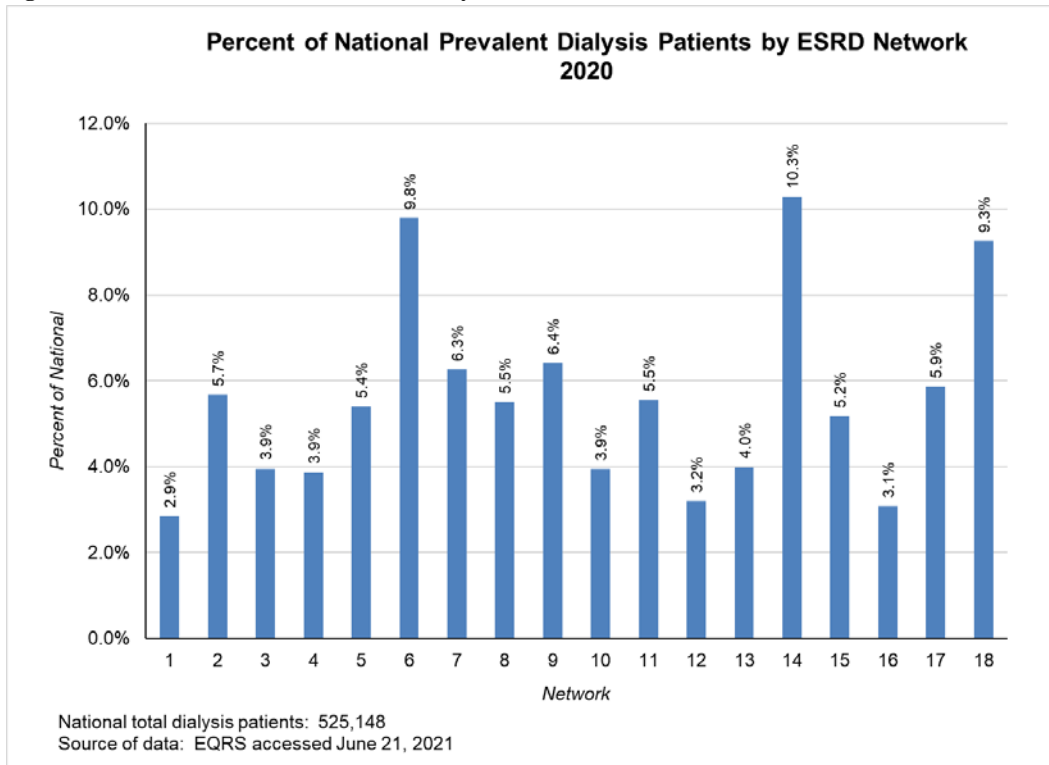


Figure 5 - Percent of Incident Dialysis Patients in each Network Service Area as of 12/31/2020

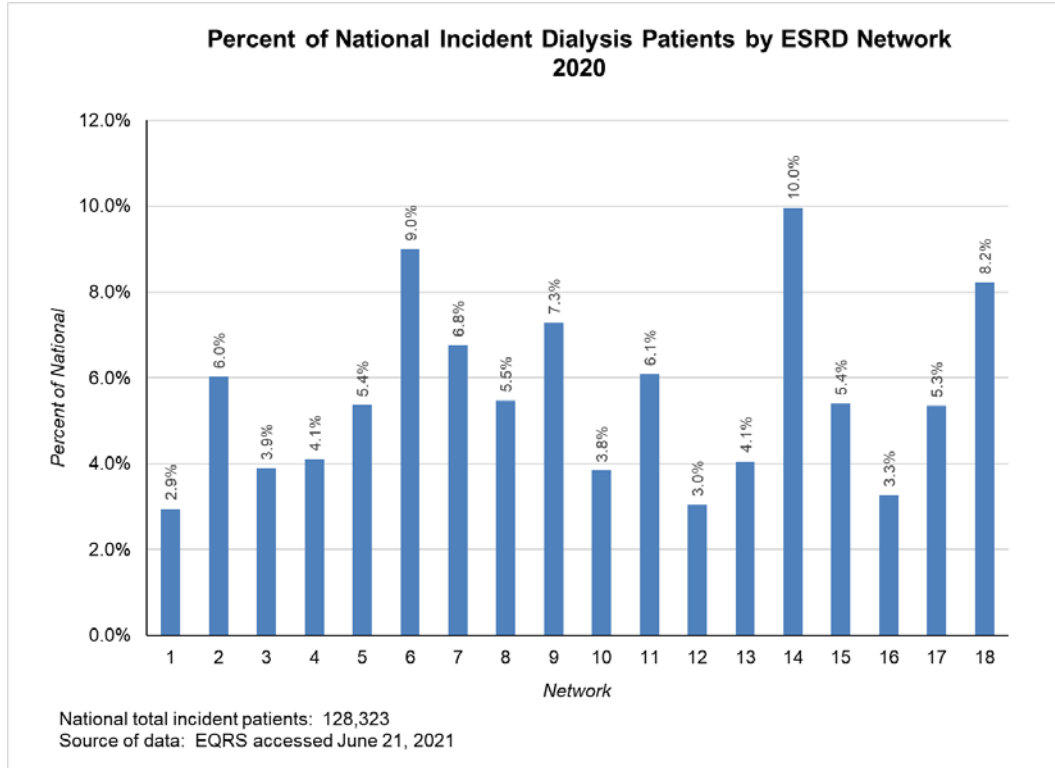


Figure 6 - Percent of Medicare-Certified Dialysis Facilities in each Network Service Area as of 12/31/2020

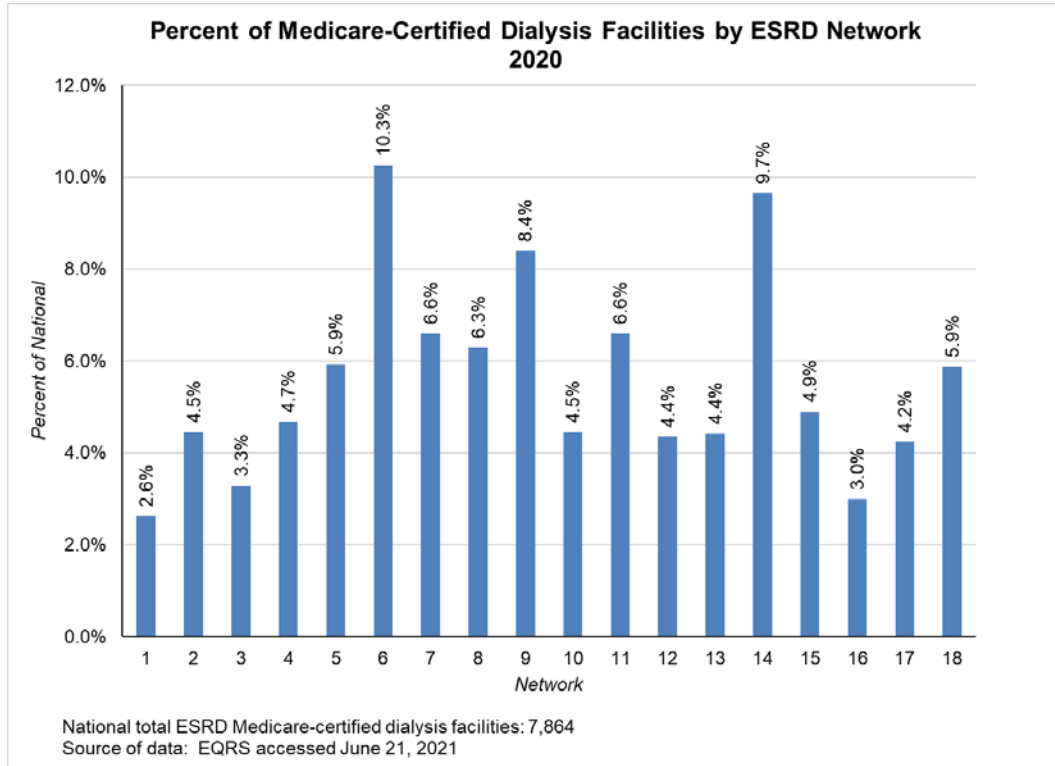


Figure 7 - Percent of National Home Hemodialysis and Peritoneal Dialysis Patients in each Network Service Area as of 12/31/2020

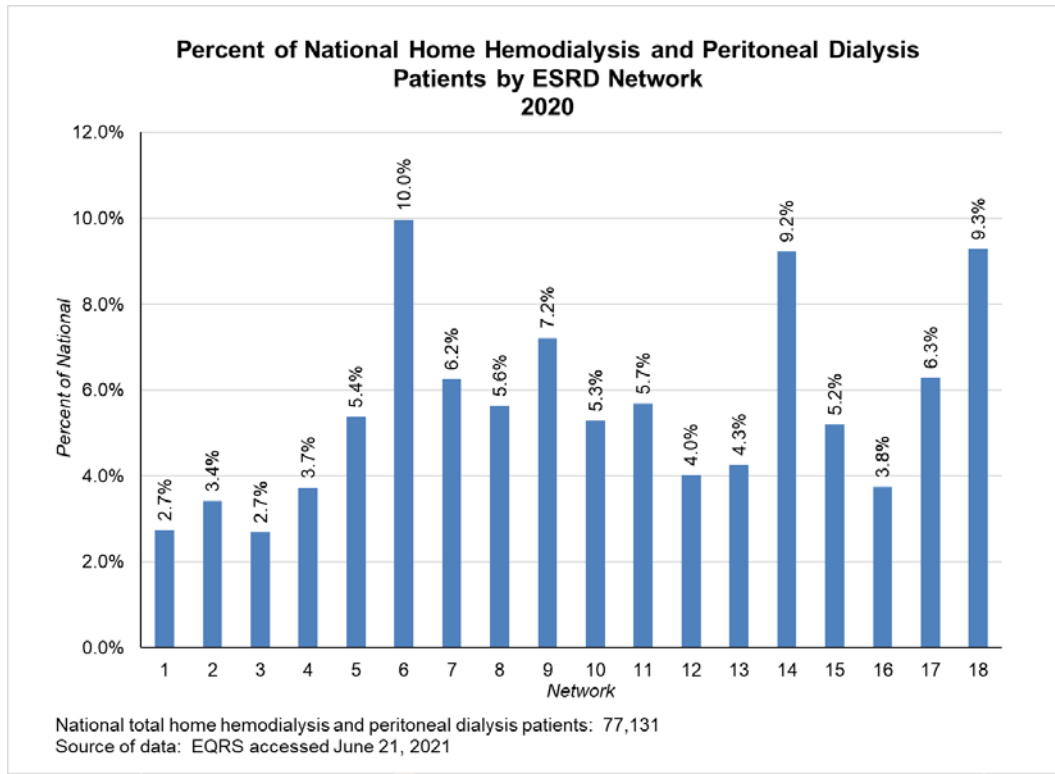


Figure 8 - Percent of National Total Transplants Performed in Each Network Service Area as of 12/31/2020

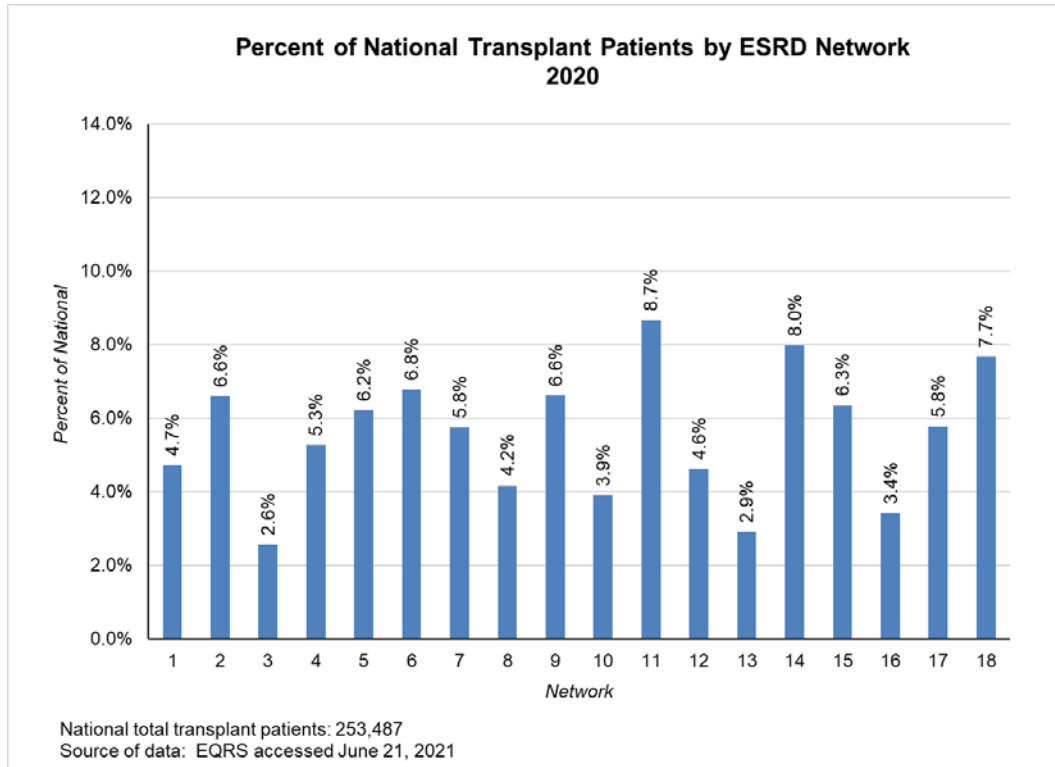


Figure 9 - Percent of Medicare-Certified Kidney Transplant Facilities in Each Network Service Area as of 12/31/2020

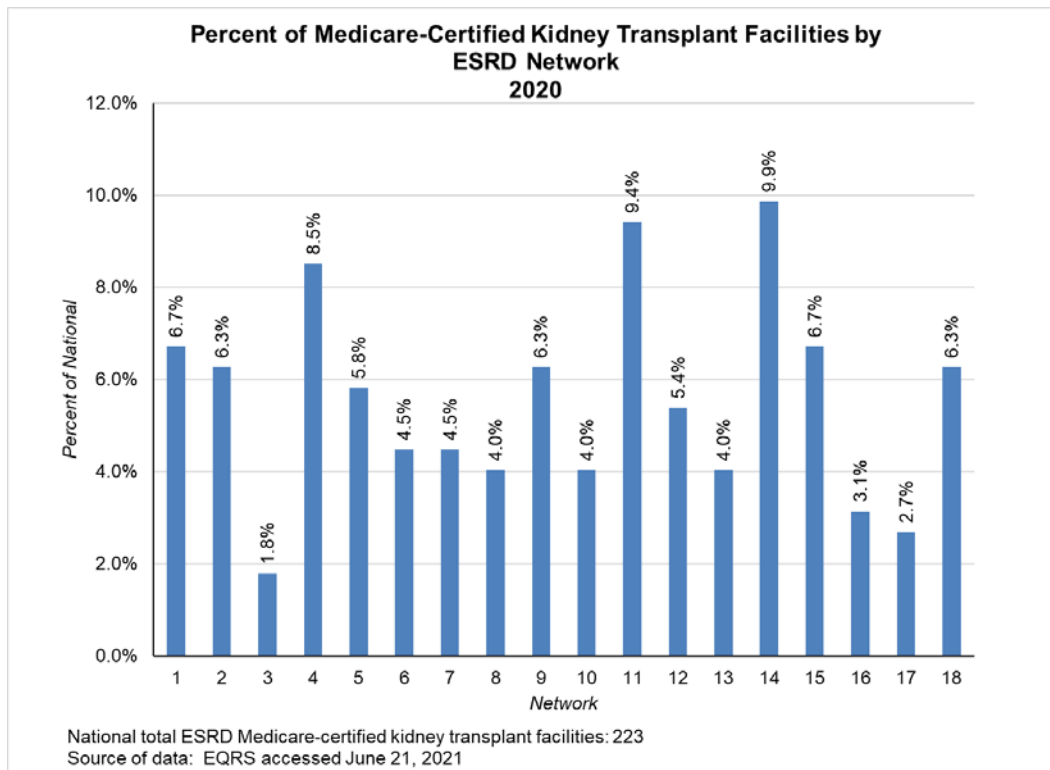
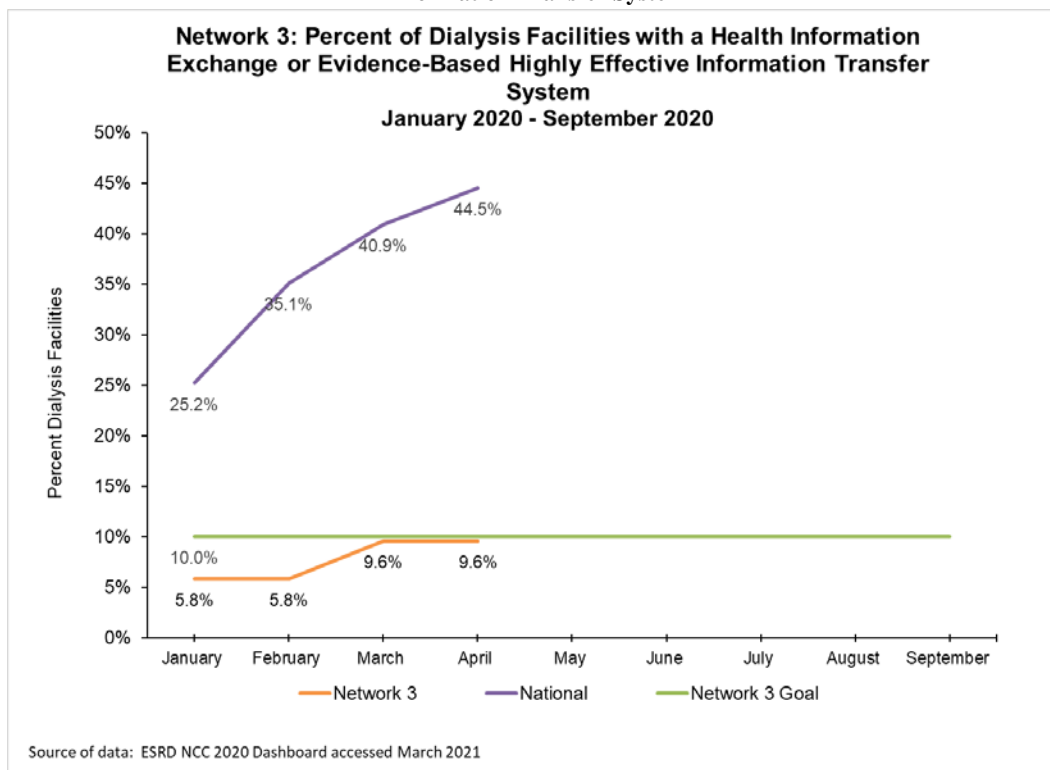


Figure 10 - Percent of Dialysis Facilities with a Health Information Exchange or Evidence-Based Highly Effective Information Transfer System





ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA

The ESRD Network contract states 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 began 2020 with the anticipation that we would be able to reach out to patients at their facilities whenever a grievance warranted an onsite investigation but that opportunity was short lived due to the COVID-19 pandemic. The onset of the pandemic resulted in a lockdown at dialysis facilities that prevented us from providing any onsite grievance investigations. Any work related to COVID-19 specific grievances or general grievances was completed remotely. As the months progressed, the number of COVID-19 grievances we received was far less than anticipated. We had only one immediate advocacy case related to COVID-19, and one access to care case filed by a patient’s daughter.

In August 2020 the grievance flyer, *I am a Kidney Patient, What Can I Do if I Have a Grievance?*, was mailed to all the dialysis facilities in our service area. The flyer outlined the grievance process and explained their right to file a grievance. We required that a facility staff member attest to the receipt and distribution of the flyers to all patients in the facility. This ensured that each dialysis patient was educated in 2020 on their right to file grievances. Information about filing grievances was also included in our Patient Advisory Committee (PAC) newsletters three times in 2020. These newsletters were also mailed to each facility for distribution to patients.

We employ trained social workers and nurses who are adept at managing patient and/or family members’ grievances. Our staff’s collective experience as direct care practitioners in both dialysis and transplant settings allows us to understanding the dynamics of these settings. It also allows us to investigate the grievances received with the skills necessary to ensure a fair and patient-centered approach to the investigation. Twenty-one calls were received in 2020 where we provided immediate advocacy. These cases included treatment related/quality of care issues, staff-related issues, and physical environment concerns.

In 2020 our staff investigated two Clinical Quality of Care cases filed by patients. These cases required the review of medical records by a registered nurse. They resulted in recommendations for the staff with regard to appropriate care of the patients. These types of cases are also teaching opportunities for the staff that ultimately impact the well-being of all patients at these facilities.

We are also responsible for addressing Access to Care cases with our providers. In 2020 we had 51 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. In total, we had 13 IVDs and 30 At-Risk cases. Of the 30 At-Risk cases, 26 were averted. Twenty-five of the patients

remained at their facilities and one patient voluntarily transferred to another facility. We also had four Access to Care cases filed by patients in 2020.

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 addressed 56 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. As evidenced by the relatively low number of IVD/IVT cases in 2020, these interventions have been successful in maintaining at-risk patients in their facilities.

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

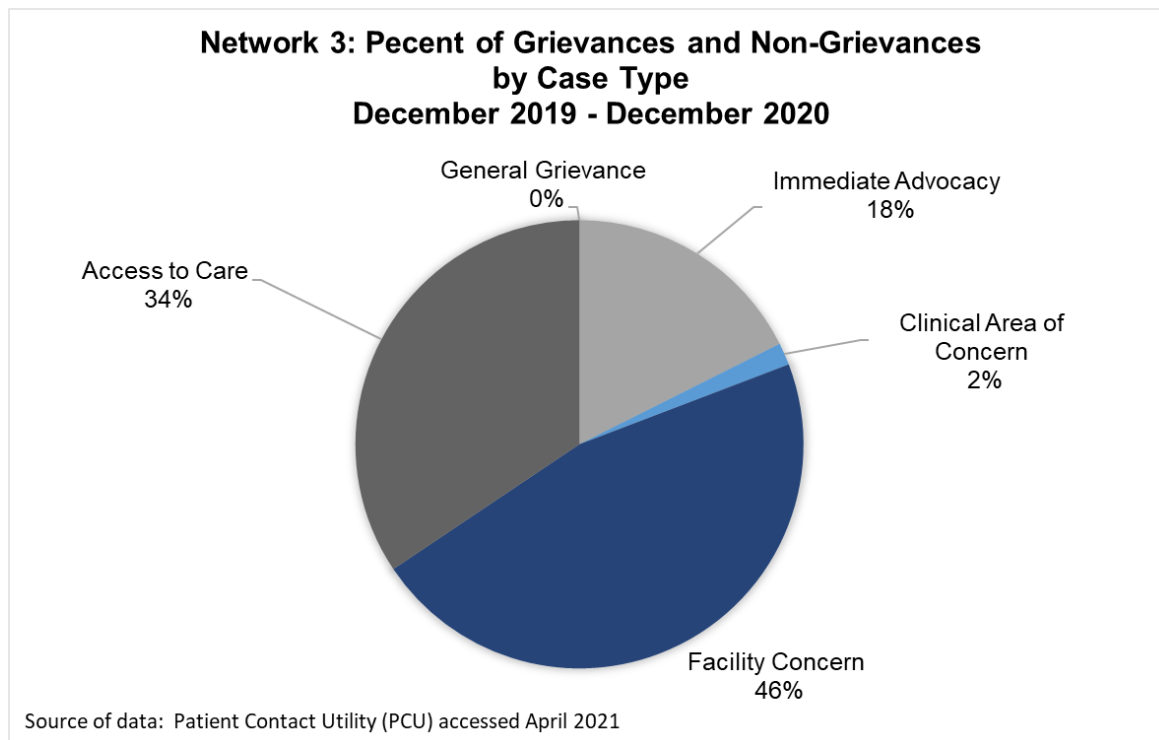
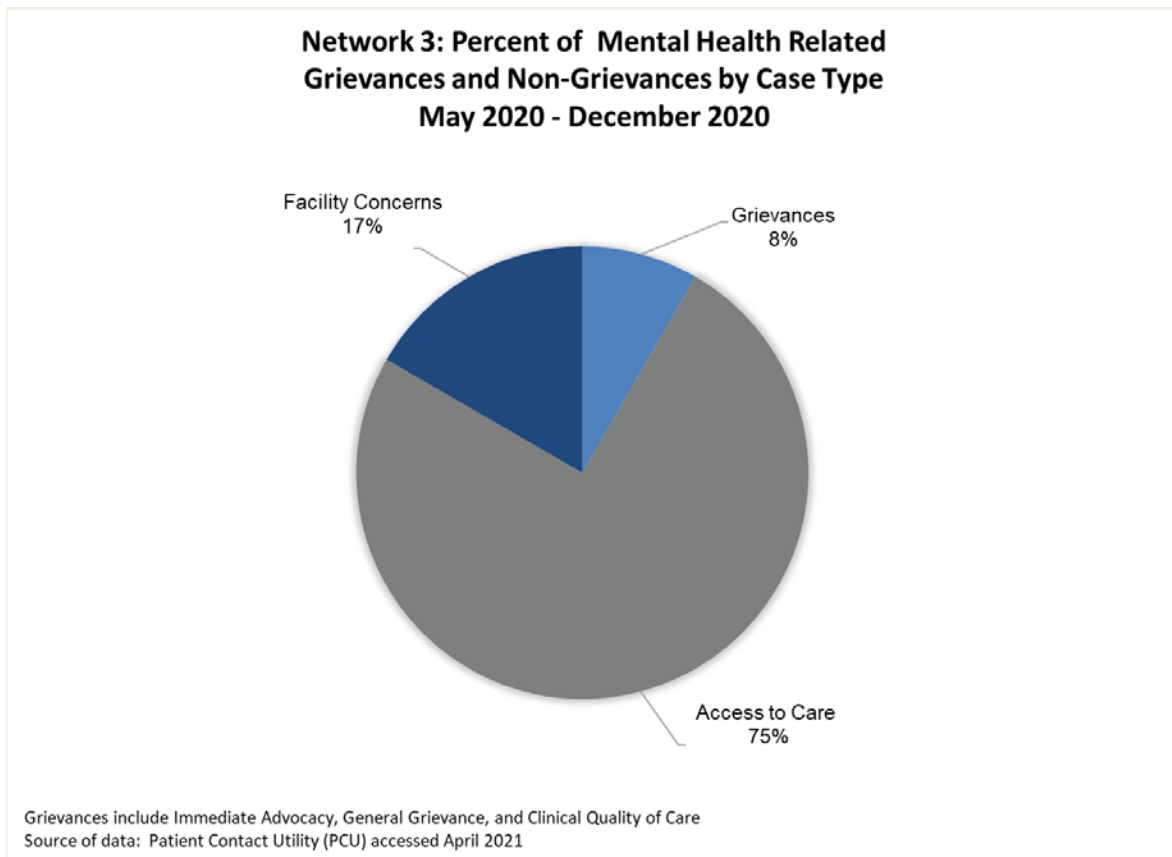


Figure 12 - Percent of Mental Health Related Grievances and Non-Grievances by Case Type (May 2020-December 2020)





ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA

Long Term Catheter 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.

In this Quality Improvement Activity (QIA) our goal was to reduce the use of long- term catheters (LTC) by supporting facilities in addressing factors hindering their achievement of the catheter reduction goals.

Dialysis facilities in southern New Jersey reported having limited access to quality surgeons, being challenged by physician referral patterns, and staff turnover resulting in ineffective tracking and follow up.

Puerto Rico facilities reported issues related to insurance preauthorization requirements, limitations by insurance providers, such as, limited or in some cases no vascular surgeons in their provider network, limited coverage for transportation, patients not completing the process due to limited financial resources for transportation or lack of family support, poor collaboration and/or cancellation by vascular centers and or surgeons.

All facilities in the Network 3 service area were provided education and technical assistance in the identification and management of patients with opportunities for a permanent vascular access.

Educational support began with an in person meeting in December 2019. Experts provided education on new vascular access placement techniques and provided tools and resources to assist facilities in the early education of patients. They also showed the facilities how to follow the steps toward catheter freedom. Patient level reports were then provided to assist in the focus on catheter reduction. We promoted attendance to ESRD National Coordinating Center Learning and Action Network (NCC LAN) calls where best practices were presented. The links to these calls were provided for those that may have missed the live presentations. We promoted the ESRD NCC Lifeline for a Lifetime tools for patient and staff education as well as guides for monitoring new vascular accesses.

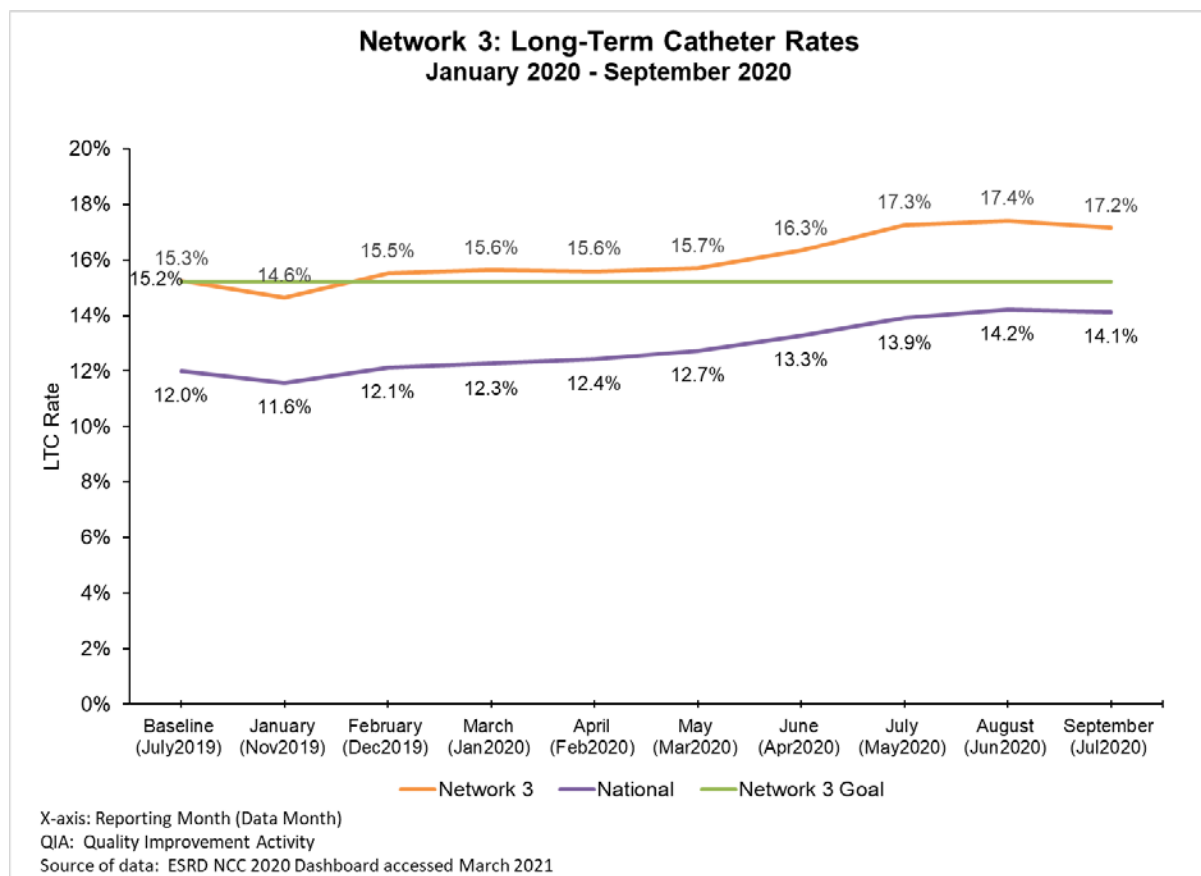
We guided and assisted dialysis facilities through the implementation of best practices related to timely education and referral and we supported the engagement of patients to actively participate in the vascular access evaluation and placement process. A patient level tracker tool was made available for facilities needing assistance with monitoring patients through the steps in the process and education was provided on how to implement this tool.

We met with dialysis organization leadership at the onset of the performance period to explore ways to collaborate and continued to provide support throughout the pandemic to address issues that arose. One barrier presented itself soon after the onset of the pandemic. It was related to the cancellation of vascular access appointments as these were deemed to be nonessential. These cancellations stalled new access placements and challenged routine vascular monitoring procedure appointments. In addition, facilities reported that patients were not keeping appointments for fear of becoming infected with the COVID-19 virus.

Eventually, clarification was provided that vascular access procedures were considered essential and we received feedback from representatives of our medical review board and dialysis leadership that improvement was being observed with the ability to schedule patients for vascular access procedures.

Unfortunately, the time lost due to the limitations to vascular access services during the pandemic exacerbated preexisting patient and provider barriers.

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



Blood-Stream Infection Quality Improvement Activity

In this initiative, we assisted dialysis facilities in the implementation of the Center for Disease Control and Prevention (CDC) Core Interventions and Audit tools through education, audits, and feedback using the Institute for Healthcare Improvement (IHI) model for improvement.

We implemented a multi-pronged QIA to reduce dialysis event rates, specifically BSI rates, and exceeded the CMS goal of a 20% or greater relative reduction in the pooled mean at re-measurement (first- and second-quarter of 2020) compared to the baseline (first- and second-quarter of 2019).

Focus facilities were supported in the implementation of the CDC Core Interventions and appropriate use of the CDC Prevention Process Measure audit tools. We worked with 49 focus facilities and provided a bundle of tools and resources through our QIA Promote and encourage use of the CDC's Making Dialysis Safer Coalition materials, including the *Days Since Last BSI* poster, *Conversation Starter to Prevent Infections in Hemodialysis*, and *Six Tips to Prevent Dialysis Infections*. We promoted other promising practices to reduce infections that were presented during the 2020 ESRD NCC LAN calls and encouraged attendance to calls.

We engaged patients at different levels to obtain their feedback on patient specific interventions and approaches. Through the PAC, patients participate in the identification and development of patient specific approaches and tools. Facilities participating in this activity were provided guidance in engaging patient participation in facility activities. Facility level patient subject matter experts (SMEs) presented patient concerns and input during participation in the facility quality improvement meetings. Patients were able to participate virtually after the onset of the pandemic. BSI QIA facilities had patient SMEs participate in their quality meetings from January to September 2020. There were 52 follow up actions taken by facilities as a result of the discussions presented by patient SMEs. These actions included the facility provided patient education, staff education or follow up, and patient volunteers. One patient volunteered to conduct staff hand hygiene audits and another to speak with other patients about transitioning from a catheter to a fistula or graft.

The COVID-19 pandemic brought heightened awareness to the need for effective infection prevention practices while it challenged facility staff adherence to these as a result of limitations in availability of personal protective equipment (PPE), staffing shortages, rapidly changing guidance for use of PPE, environmental disinfection, patient and visitor screening, and overall care of patients in dialysis settings.

We supported facilities and patients through these changing times with streamlining communication using our newsletters, weekly emails, through postings and updates on our website, social media accounts and through individual technical assistance calls. To support facilities in the evaluation of adherence to appropriate hand hygiene using hand sanitizer, we collaborated with the ESRD NCC on the development of the *Hand Hygiene with Hand Sanitizer* audit tool.

Focus facilities were encouraged to complete the Quality Insights 5 Diamond Program COVID-19 module. The module was developed in partnership with the American Society of Nephrology (ASN) and covers guidance for dialysis providers released by the CDC. Ninety-one percent (91%) of the BSI QIA facilities completed the module.

We provided ongoing support to ensure complete and accurate reporting of dialysis events in the CDC National Healthcare Safety Network (NHSN). All facilities in the network service area were supported through the completion of required annual NHSN training and were guided to a bundle of resources and tools to support their alignment with the recommended practices.

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

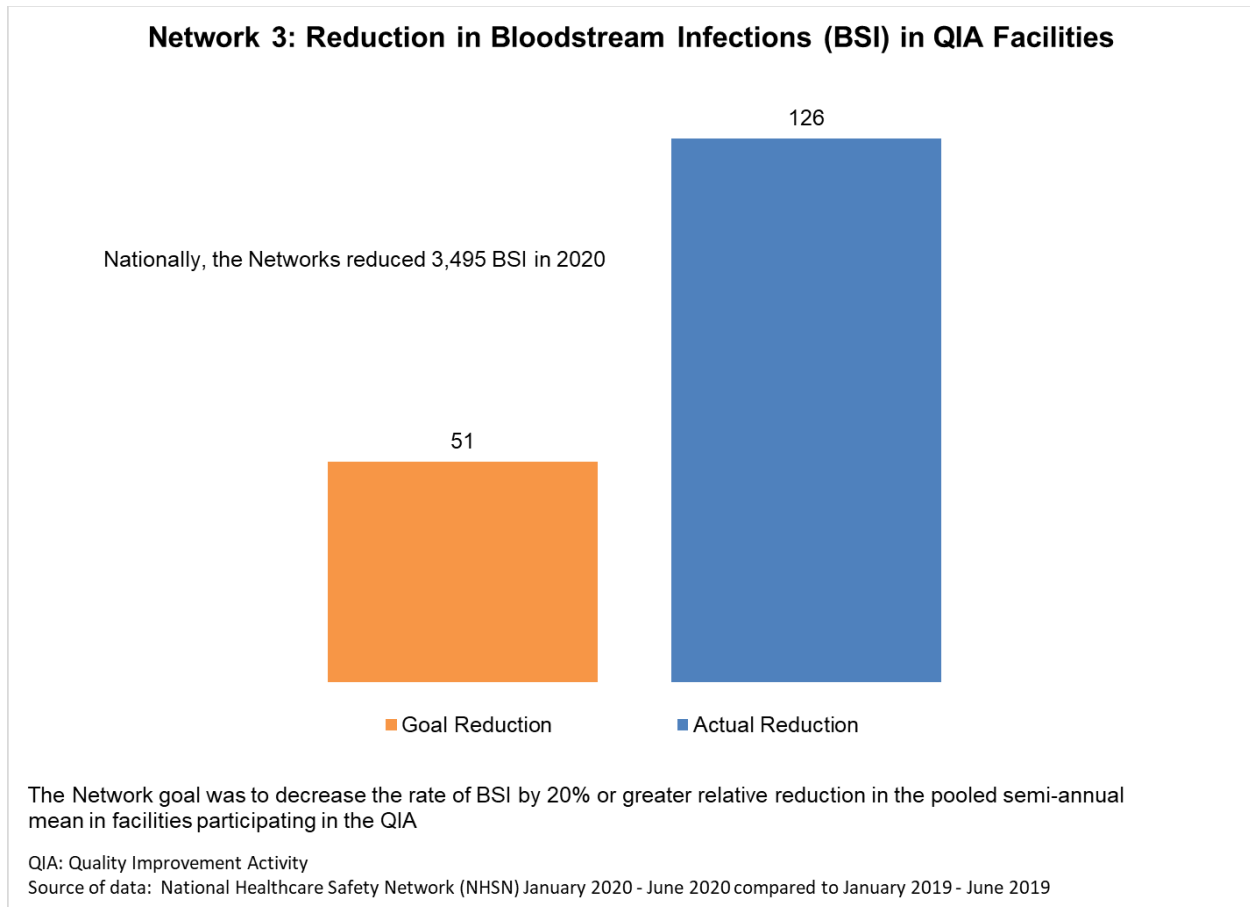
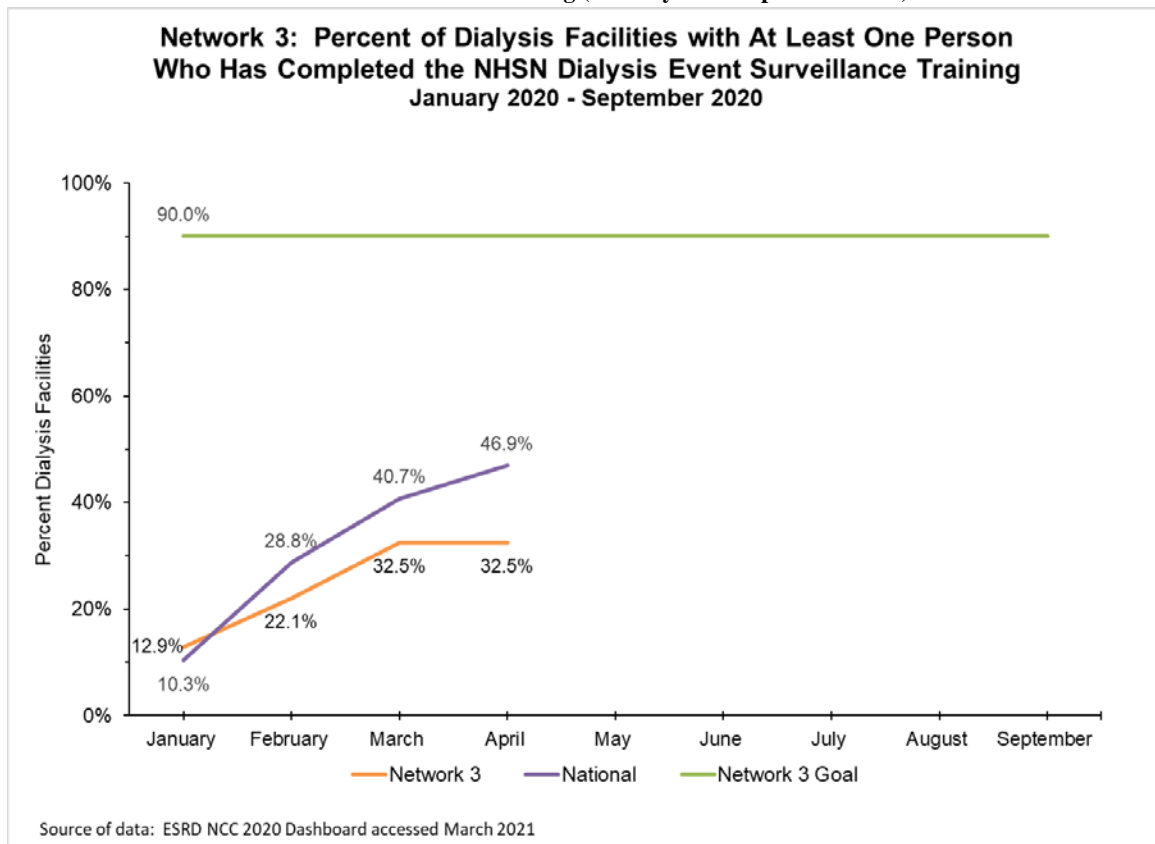


Figure 15 – Percent of Dialysis Facilities with At Least One Person Who has Completed the NHSN Dialysis Event Surveillance Training (January 2020-September 2020)



Transplant Waitlist Quality Improvement Activity

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

We supported the Advancing American Kidney Health Initiative (AAKH) goals for increasing access to kidney transplantation by improving transplant coordination across care settings.

In preparation for this initiative, we engaged dialysis facility leadership, transplant centers, patients, family members and other stakeholders to increase the number of patients added to the kidney transplant waitlist through improved communication and collaboration.

Facilities in the Network service area were provided support with education, technical assistance in the identification and management of patients with opportunities for kidney transplantation.

Educational support consisted of an in person meeting in December 2019 where transplant centers representatives were on site to educate facilities. In addition to transplant centers, the New Jersey (NJ) OPO and a pharmaceutical company representatives presented their respective transplant patient peer-to-peer programs. Patient level reports were provided to assist in the review of patient opportunities and waitlisting status. Additionally, tools and resources were provided to assist facilities in the education of patients and tracking the steps toward waitlisting.

Transplant education and waitlisting process were impacted by the public health emergency at the onset of the pandemic in March 2020. In response, we convened the NJ transplant collaborative comprised of the four NJ transplant centers, NJ OPO, NJ Department of Health (DOH) and leaders from the large dialysis organizations (LDO).

The collaborative addressed the suspended transplant center activities such as in person facility and patient education, referral, evaluation, waitlisting and transplantation in general and the suspended annual transplant designee education that is a NJ state required annual transplant designee certification. As a result:

- We coordinated transplant center communications regarding operational updates to the stakeholders.
- We collaborated with transplant centers in providing education to dialysis facilities through webinars.
- We partnered with NJ OPO in the establishment of virtual peer-to-peer transplant education support to dialysis patients.
- We advocated on behalf of the dialysis facilities to the NJ DOH to waive the 2020 transplant designee certification requirement. The collaborative discussed plans for the transplant designee certification programs in 2021.

Subsequently, we now serve as the coordinator of transplant designee programs annual schedule through the Transplant Designee Information Hub, a central location for upcoming and past transplant education events.

We implemented the ESRD NCC Kidney Transplant Change Package and provided the supplemental resources to support increasing the number of patients referred to transplant centers, evaluated for kidney transplantation, and placed on transplant waitlists. The change package and the supplemental resources

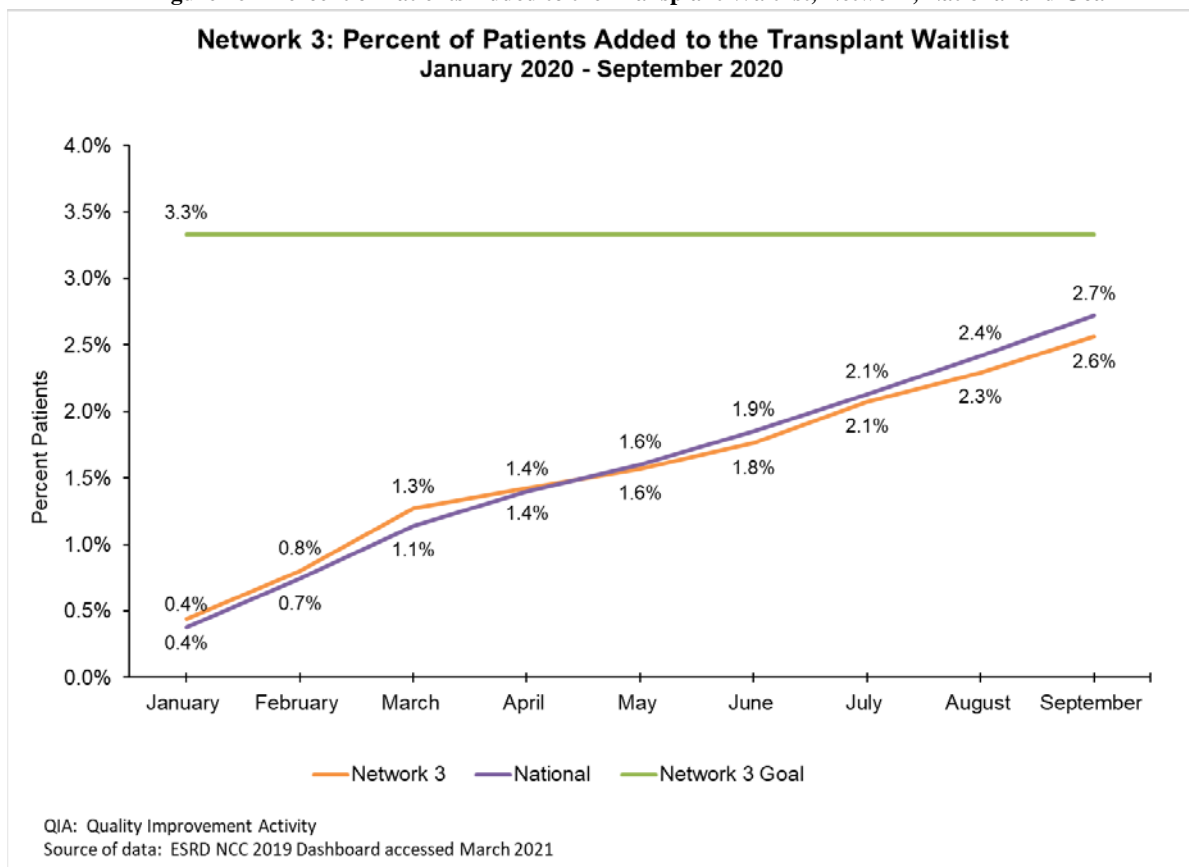
and tools were made available on our Transplant QIA web page <https://www.qim3.org/Ongoing-Projects/Improving-Transplant-Listing-QIA.aspx> .

We engage patients at different levels to obtain their feedback on the patient specific interventions and approaches. Through our PAC, patients participate in the identification and development of patient specific approaches and tools. Facilities participating in this initiative were provided guidance in engaging patient participation in facility activities. Patient contributions to the transplant QIA include:

- Provision of support and education to fellow patients regarding the transplant evaluation process.
- Identification of new ways to work with patients not interested in transplantation or need to overcome certain challenges.
- Review and revision of patient or staff material.
- Facilitation and or participation in a lobby day focused on transplant (prior to the pandemic).

We continue to provide support and updates to patients, dialysis facilities, and transplant centers in continuing efforts to increase kidney transplant waitlisting and living donation.

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



Home Therapy Quality Improvement Activity

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

Until the 2020 Home Therapy Quality Improvement Activity (Home Therapy QIA), our service area had lagged behind the nation in improvement in home dialysis utilization despite efforts in recent years. Unlike some other regions, there is a high density of dialysis facilities in our service area, making it very convenient for physicians to send patients in center for hemodialysis. In preparation for the 2020 Home Therapy QIA, we met with leadership from the dialysis organizations to support the AAKH goals with the promotion of a collaborative approach to increasing appropriate home dialysis utilization.

We addressed barriers to home dialysis utilization prevalent to our service area, such as, patient interest, lack of physician engagement, and ineffective facility processes for educating and referring patients for home modality evaluation.

Facilities in our service area were provided support through education, technical assistance in the identification and management of patients with opportunities for a home modality. Educational campaigns were promoted to address facility level opportunities for improvement, such as physician engagement, patient and/or staff education and facility processes.

Educational support began with an in person meeting in December 2019, where we educated facilities on the AAKH goals. We enlisted experts in home dialysis modalities who provided education on how to effectively identify patients that could benefit from a home modality.

We provided patient level reports to assist in the review of incident and prevalent patients that were receiving in center hemodialysis. Trigger questions were provided in an instructional tool to guide the facility in the reconsideration of patients that were previously disregarded for reasons such as non-adherence. The goal was to identify and address modifiable factors that had prevented patients from pursuing a home modality.

We guided facilities to best practices and encouraged attendance on ESRD NCC LAN calls where best practices were presented. Technical assistance was provided to ensure dialysis facility staff were knowledgeable on the use of the tools and we assisted in the thoughtful consideration or reconsideration of patients that could benefit in the transition to a home dialysis modality. A bundle of tools and resources was offered to assist in the evaluation and monitoring of patients transitioning through the seven steps from determination of interest to a home modality setting.

The onset of the COVID-19 pandemic presented challenges as well as opportunities for the Home Therapy QIA. The impact of the pandemic on home therapy services varied by facility and region. We ensured facilities were knowledgeable about the updated telemedicine guidance and the ESRD NCC Telemedicine Toolkit. We collaborated with patient SMEs on a newsletter titled, *Renal Patients in a World of Telehealth* which highlighted benefits, barriers, tips, and things to ask during home therapy telehealth visit.

We shifted to a voluntary participation in the Home Dialysis Options Awareness Campaign. The Home Dialysis Options Awareness Challenge is an innovative campaign that seeks to increase home dialysis utilization through the development of educational and quality improvement programs. Through the Home Dialysis Options Awareness Challenge, we aimed to foster a culture of collaboration, teamwork,

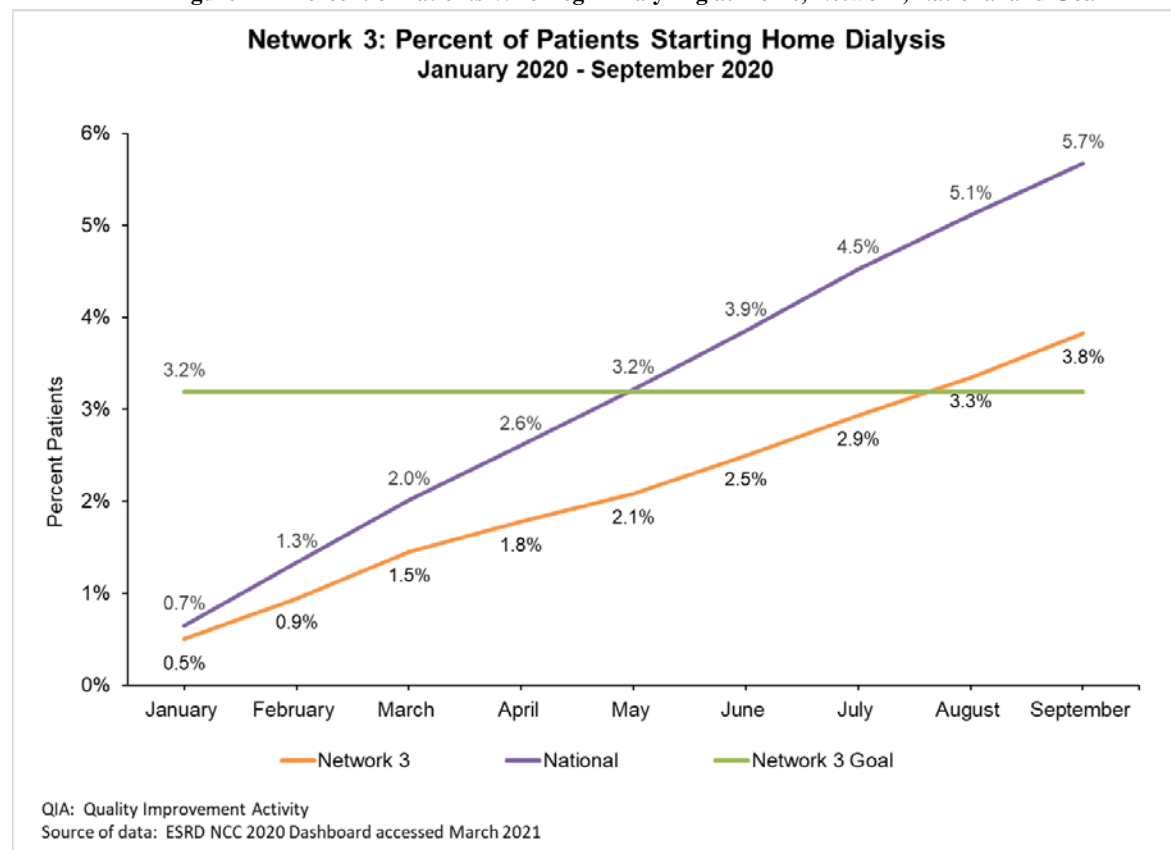
and communication between clinicians, in center only, multiservice dialysis facilities and patients to promote the Advancing American Kidney Health Initiative:

- Improve access to and Quality of Person-Centered Treatment Options.
- Promote educational campaigns for dialysis facility staff and patients.
- Create opportunity for knowledge sharing amongst in center only and multiservice dialysis facilities.
- Encourage the development of quality improvement projects to increase interest and utilization of home treatment options.

Thirty-three of 77 facilities that were invited to participate, volunteered and completed the campaign activities. Two facilities, one in New Jersey and one in Puerto Rico, were selected by our Medical Review Board for their innovation, collaboration, and results.

Despite the challenges brought on by the COVID-19 pandemic that included staffing shortages, rapidly changing guidance for how visits were conducted and how patients were cared for, we led the ESRD Networks in improvement of home dialysis utilization. This is attributable to a focused and collaborative approach to home dialysis education and improvements in the accessibility and timeliness of patient identification and referrals to home modalities.

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



Population Health Focus Pilot Project Quality Improvement Activity

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

Prior to the suspension of the Population Health Focus Pilot Project Quality Improvement Activity (PHFPQ), we had worked with a select group of 25 dialysis facilities on the Increasing Gainful Employment QIA. We selected all DaVita facilities for this year's project in the anticipation that they would feel comfortable sharing strategies and outcomes with one another.

Each of the facilities was visited in-person by a Network staff member to review the project guidelines and reporting requirements. Education was provided to the interdisciplinary staff at each of these facilities. Information on the Social Security Ticket to Work Program was provided to facility staff. A plan was established to assess each of the patients in the facilities between the ages of 18-64 for appropriateness of a referral to an Employment Network or the State Division of Vocational Rehabilitation. The goals of the project were outlined to ensure the facility staff would begin the project with an understanding of how many patients needed to be assessed and referred for employment training.

The onset of the COVID-19 pandemic resulted in the closure of Vocational Rehabilitation offices and Employment Networks therefore this project was suspended. There was a stay-at-home order issued in NJ which made it unlikely that dialysis patients would be able to pursue employment. Facility social workers who were running the project were involved in the activities of the units focused on managing the pandemic. They were informed of the project suspension and encouraged to maintain a list of patients who would be appropriate for Ticket to Work in the future.

Figure 18 – Percent of Patients Referred to Support Services

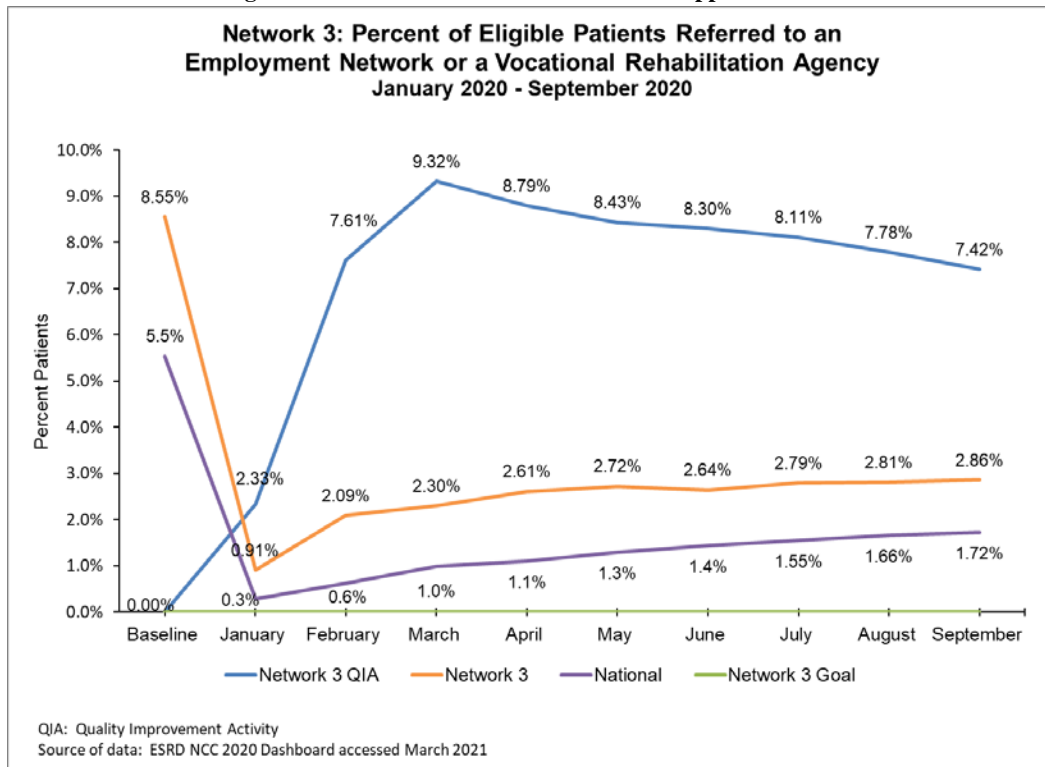
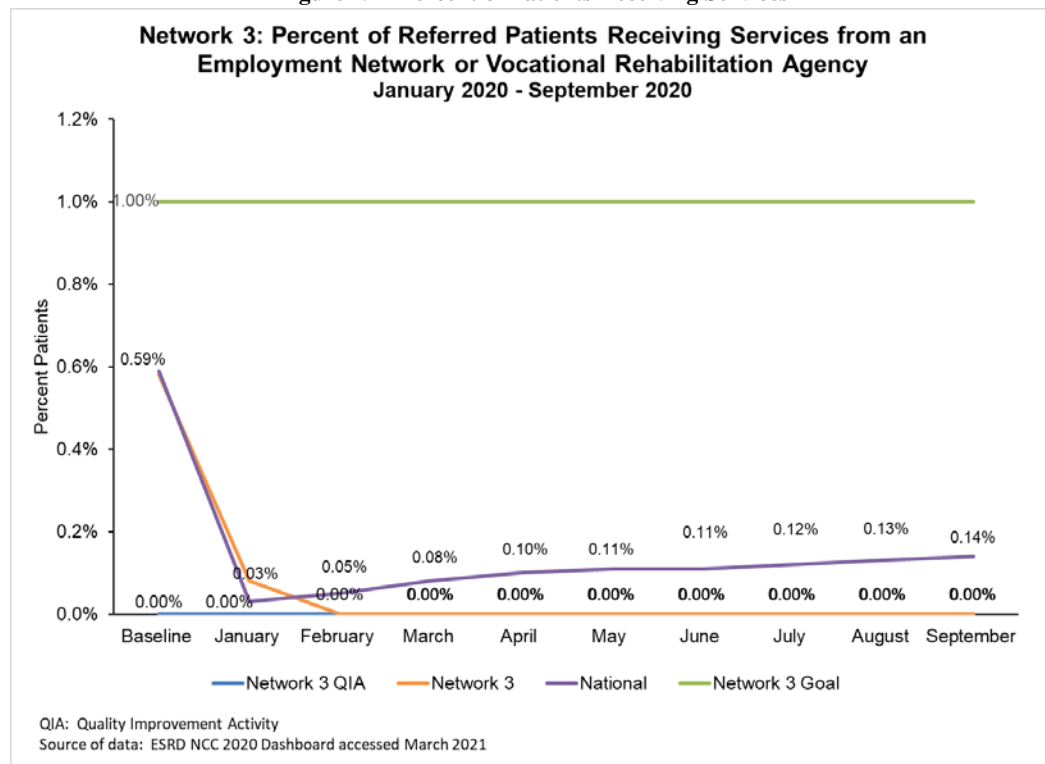


Figure 19 – Percent of Patients Receiving Services





ESRD NETWORK RECOMMENDATIONS

Facilities that Consistently Failed to Cooperate with Network Goals

All facilities in the Network 3 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 3 geographic area are well distributed and are readily accessible to patients.



ESRD NETWORK COVID-19 EMERGENCY PREPAREDNESS INTERVENTION

The 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, was 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) (<https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>). The dialysis providers, ESRD NCC, the ESRD Networks, federal public health agencies, professional associations, and the Kidney Community Emergency Response Coalition (KCER) responsible for managing dialysis care during disasters faced a unique call to action and stepped up to respond.

Starting March 5, 2020, we initiated a 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 *QIRN3 Weekly: COVID-19 Resources & Memos / Upcoming Webinars / In Case You Missed It* emails. Here we compiled all dialysis & COVID-19 pertinent information and shared it with the 253 NJ, PR and US VI 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) (<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 where one-to-one phone call were made to 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.

Our staff were active participants in the weekly and then monthly NJ Group for Access and Integration Needs in Emergencies and Disasters (NJ GAINED) and the NJ County Access and Functional Needs County Coordinators calls, which addressed COVID-19 conditions, actions, needs (current and anticipated) and status reports from state and county level agencies. Early in

the response we established weekly meetings with the Puerto Rico Emergency Preparedness and Response Activities Renal Coalition (PREPARAR-C), which has representation from the Puerto Rico Office of Emergency Preparedness and Public Health, dialysis providers, non-profit organizations, TransCita, FEMA, HHS and others. Our staff also joined in the weekly meetings with the US Virgin Islands' ESF-8 COVID-19 workgroup. Represented in group were: VITEMA; FEMA; Schneider Med Center; JFL Hospital; CKC; DHS; DOJ; Department of Licensing and Consumer Affairs and others.

Transportation was identified as a primary concern during the early stages of the COVID-19 pandemic. Dialysis providers reached out to us reporting the 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 as well as engaging our state level partners from NJ State Police – County Access and Functional Needs (AFN) group and NJ GAINED. We made referrals to the Medicaid transportation broker in NJ, Logisticare for any issues related to the companies' refusal to transport COVID-19 positive Medicaid patients. In Puerto Rico, TransCita medical transport company had a seat at the table with the PREPARAR-C group and were able to address any cases as presented by providers.

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 area.

We continually track and trend all ESRD COVID-19 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-19 data to the national "general population" COVID-19 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-19 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/>