ESRD NETWORK 3 2022 ANNUAL REPORT

This report will cover quality improvement efforts led by ESRD Network 3 from Option Year 1 of Task Order Number 75FCMC21F0003, May 1, 2022 - April 30, 2023

Quality Insights
Renal Network 3

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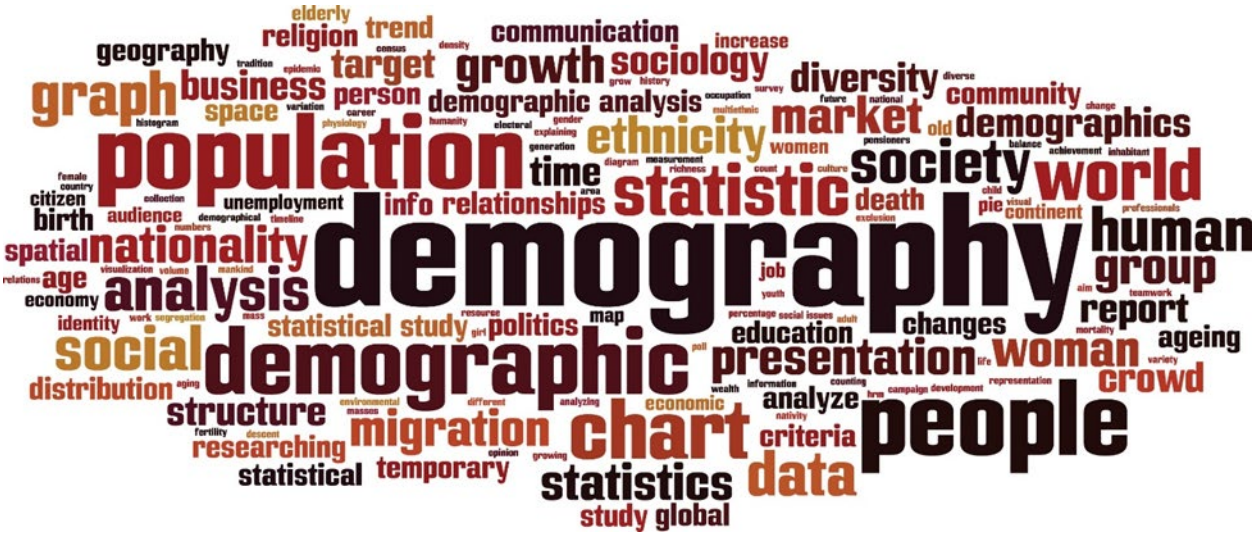
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ESRD Demographic Data

Quality Insights Renal Network 3 (QIRN3) is pleased to present our 2022 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 2022, 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 Network 3.

Geographic Description

According to the Census Bureau (https://data.census.gov), the 3 geographic areas served by QIRN3 had a combined population of 12.68 million people as of July 2020. While these three areas are geographically small in size, New Jersey (NJ) is the most densely populated state (1,206/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 2020, and had 6,247 patients receiving dialysis as of December 31, 2022. The 6,247 patients receiving dialysis in Puerto Rico was greater than the dialysis patient population of 27 states, including large states such as Oklahoma, Kentucky, Nevada, Minnesota and Colorado.

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 2022 Annual Facility Survey performed by QIRN3, 208 dialysis units in New Jersey treated an average of 67 patients in 2022, and 51 dialysis units in Puerto Rico treated an average of 123 patients, compared to an average of 57.5 nationwide. The four dialysis units in the US Virgin Islands (USVI) treated an average of 53.3 patients in 2022.

As shown in Figure 1, as of December 31, 2022 there were 18,206 patients receiving treatment in dialysis facilities in the Network 3 service area, and an additional 2,179 patients receiving treatment in their homes. This total of 20,385 patients receiving dialysis, plus an additional 7,359 patients living with a functioning kidney transplant in the Network 3 service area brings the total ESRD patient count for this area to 27,744.

The number of Medicare-Certified ESRD facilities in the Network 3 service area, by treatment modalities offered, is shown in Figure 3. In 2022 there were 5 transplant centers, 141 dialysis centers offering both in-center dialysis and home dialysis support, 112 dialysis centers offering in-center dialysis only, and 10 dialysis centers offering home dialysis support only, for a total of 263 dialysis centers and 268 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, 2022 by Treatment Modality

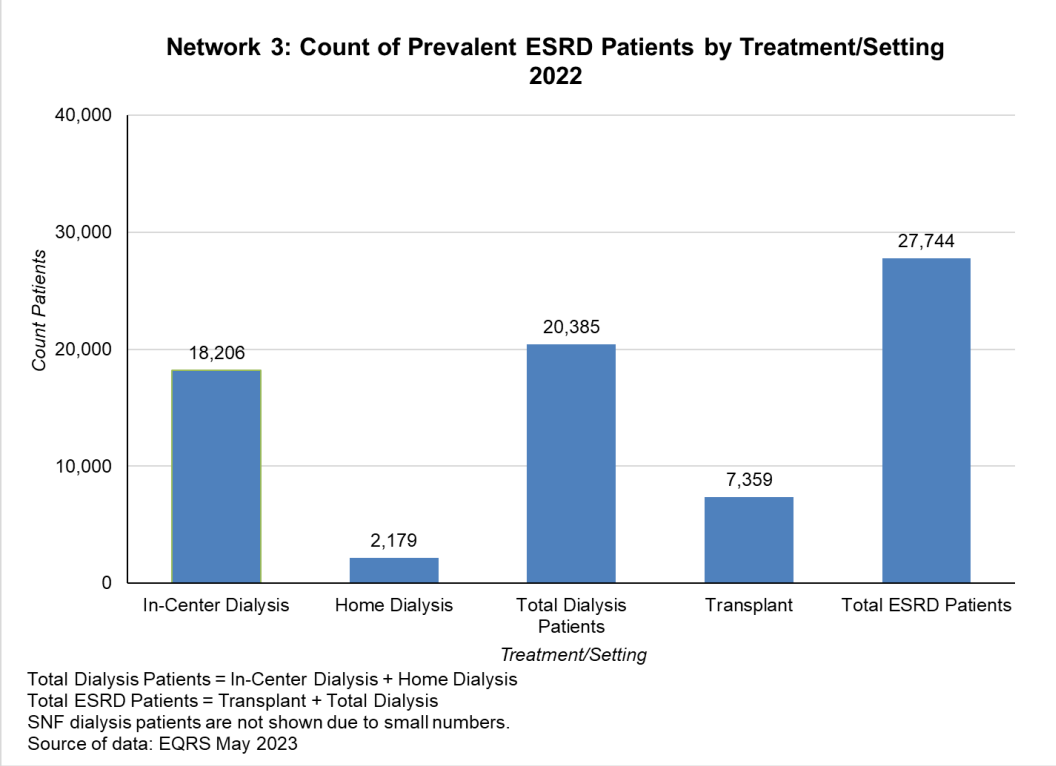


Figure 2- Number of Patients Beginning Treatment in the Network 3 Service Area in 2022 by Treatment Modality

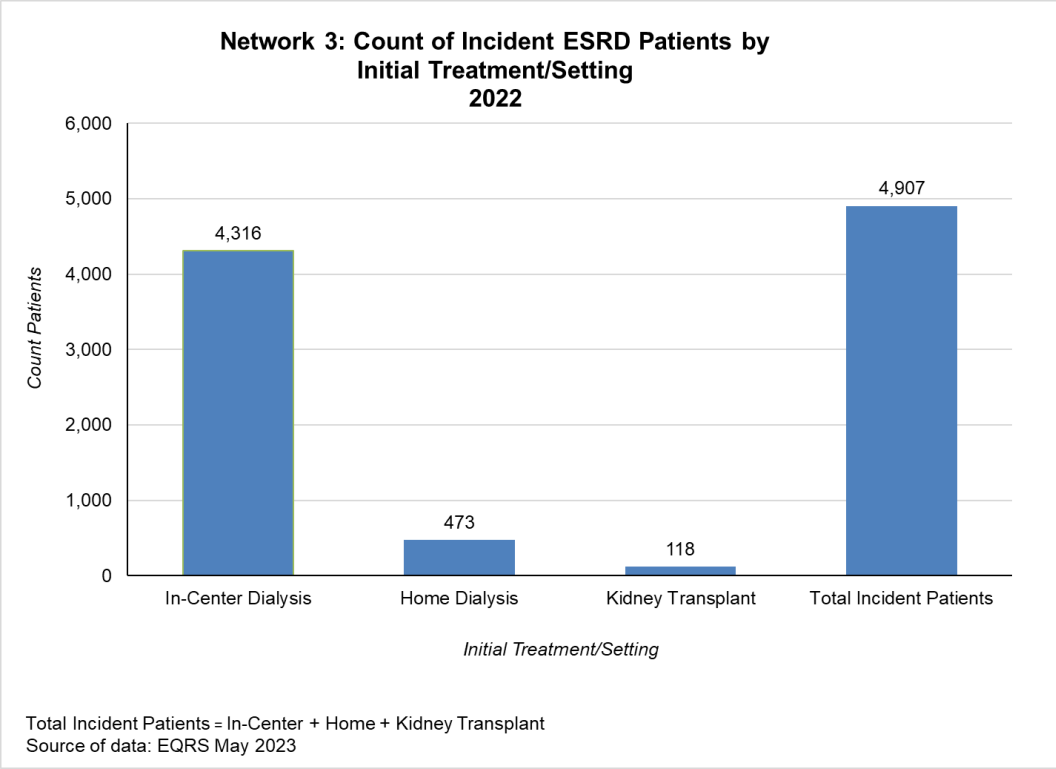
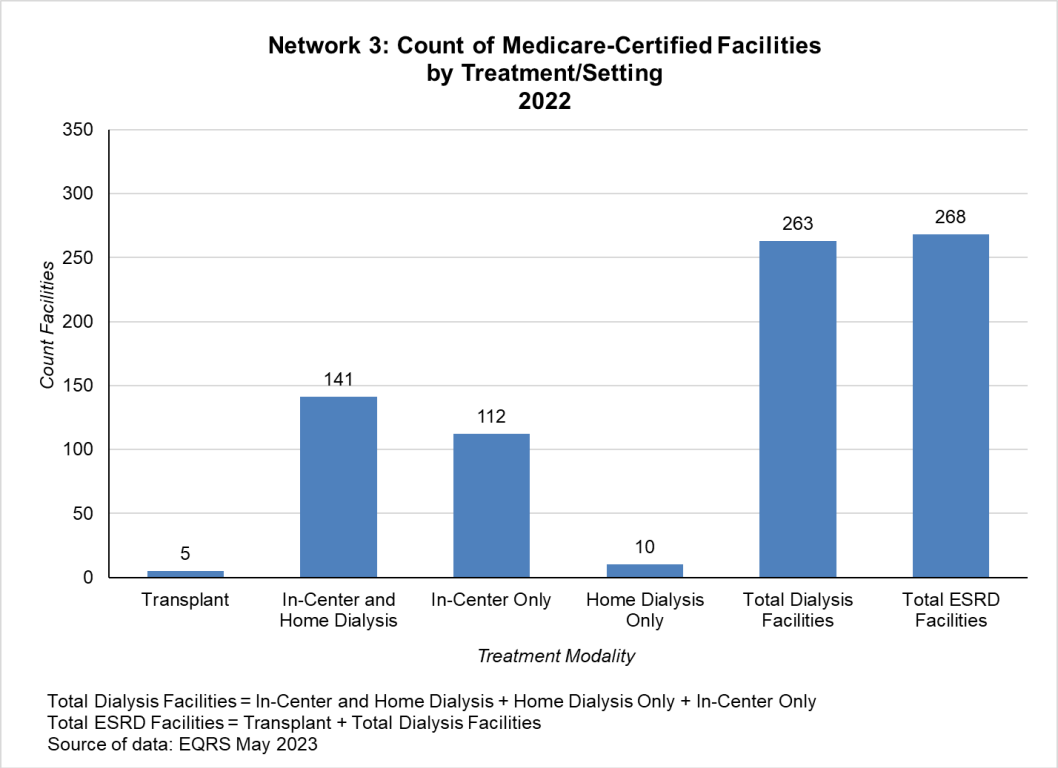


Figure 3 -Number of Medicare-Certified Facilities in the Network 3 Service Area by Modality Offered as of 12/31/2022



Total Dialysis Facilities = In-Center and Home Dialysis + Home Dialysis Only + In-Center Only
Total ESRD Facilities = Transplant + Total Dialysis Facilities
Source of data: EQRS May 2023

Figure 4 - Percent of National Prevalent Dialysis Patients in each Network Service Area as of 12/31/2022

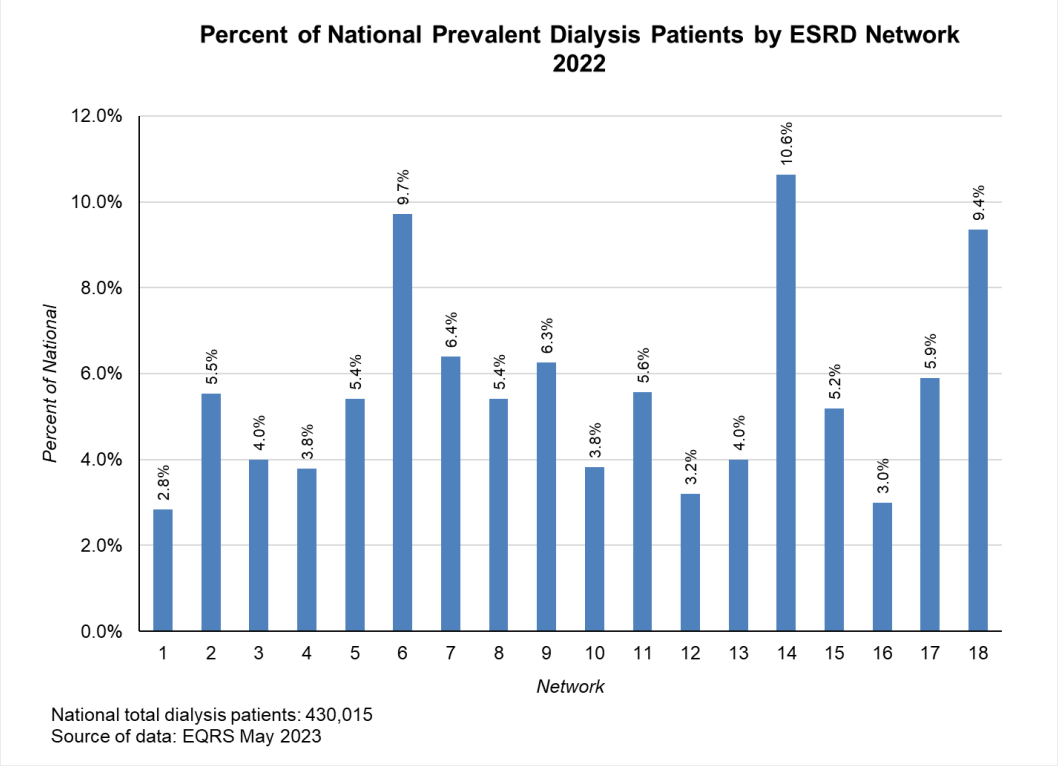


Figure 5 - Percent of Incident Dialysis Patients in each Network Service Area as of 12/31/2022

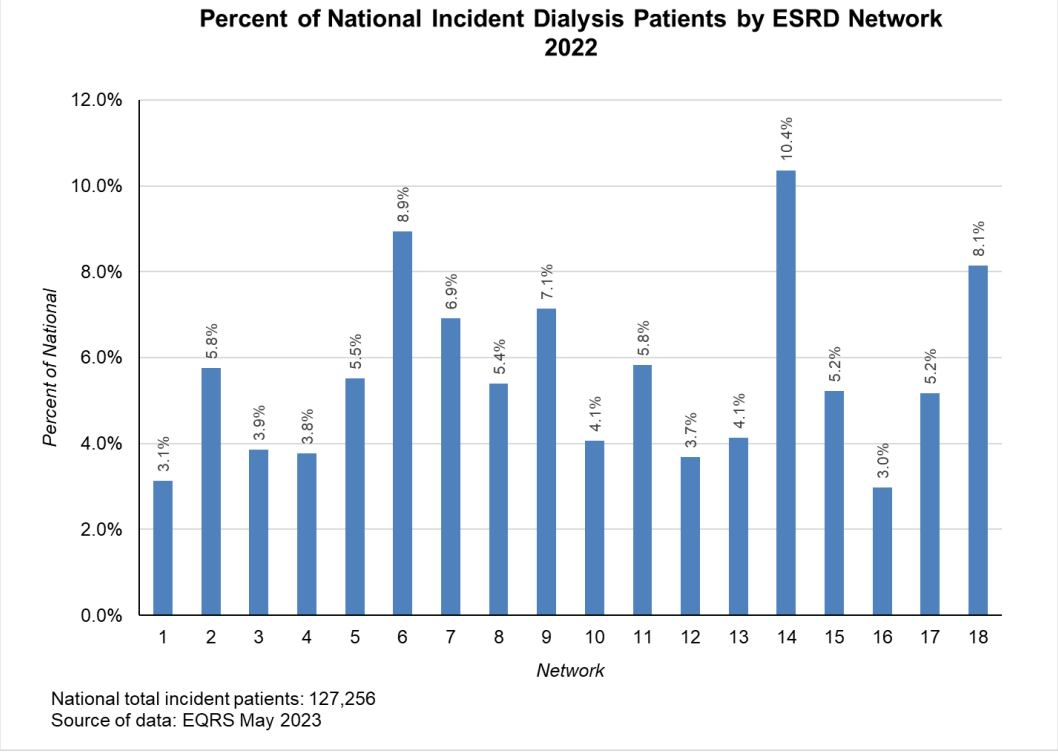


Figure 6 - Percent of Medicare-Certified Dialysis Facilities in each Network Service Area as of 12/31/2022

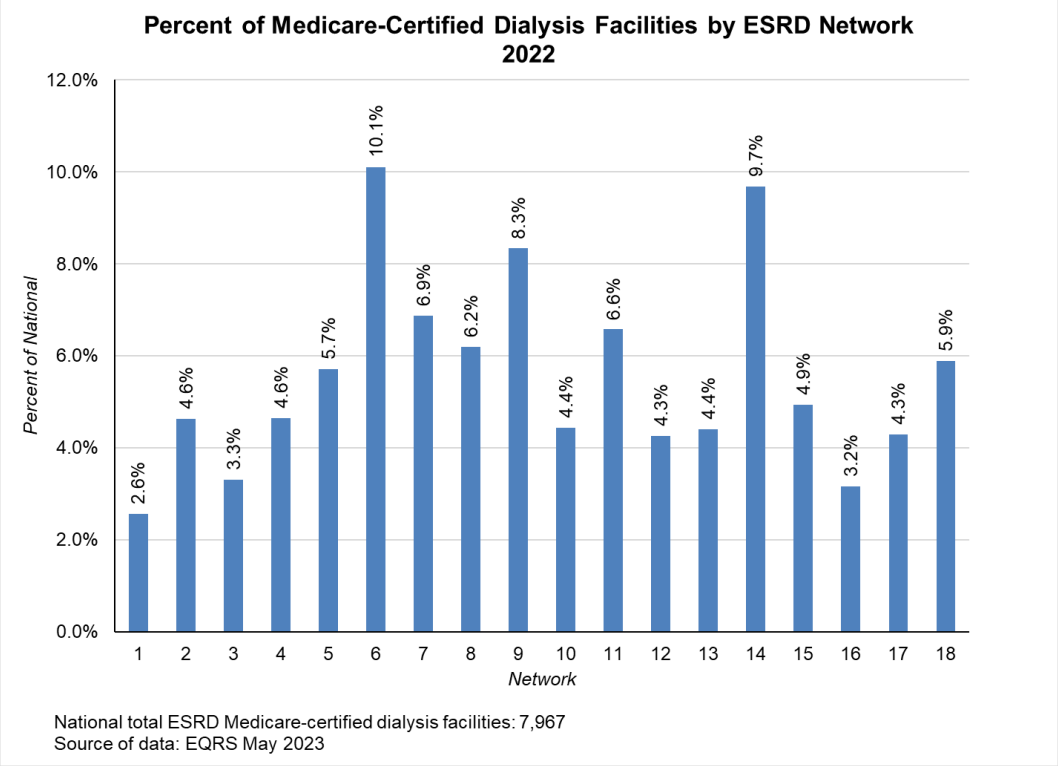


Figure 7 - Percent of National Home Hemodialysis and Peritoneal Dialysis Patients in each Network Service Area as of 12/31/2022

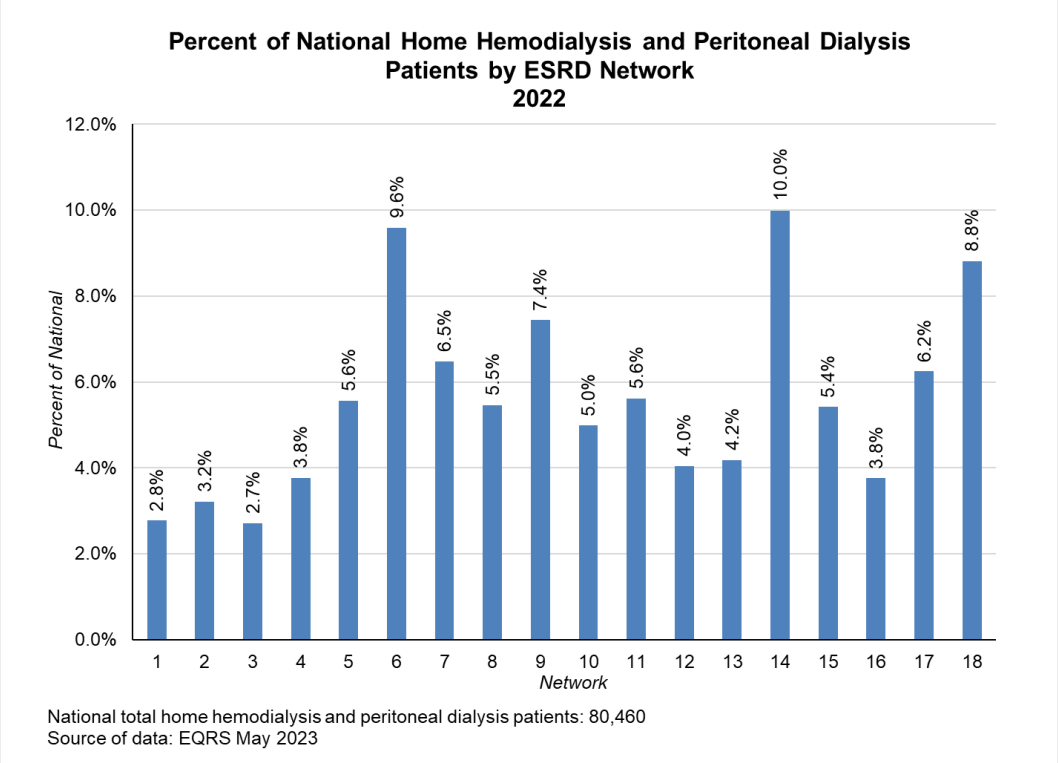


Figure 8 - Percent of National Total Transplants Performed in Each Network Service Area as of 12/31/2022

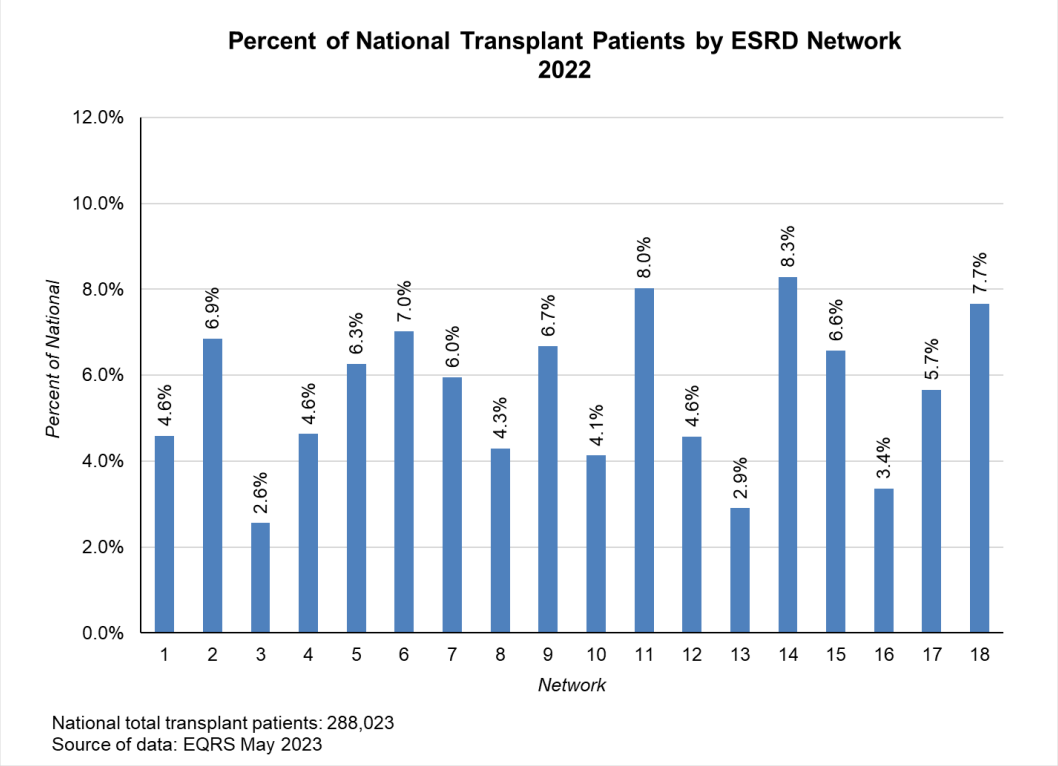
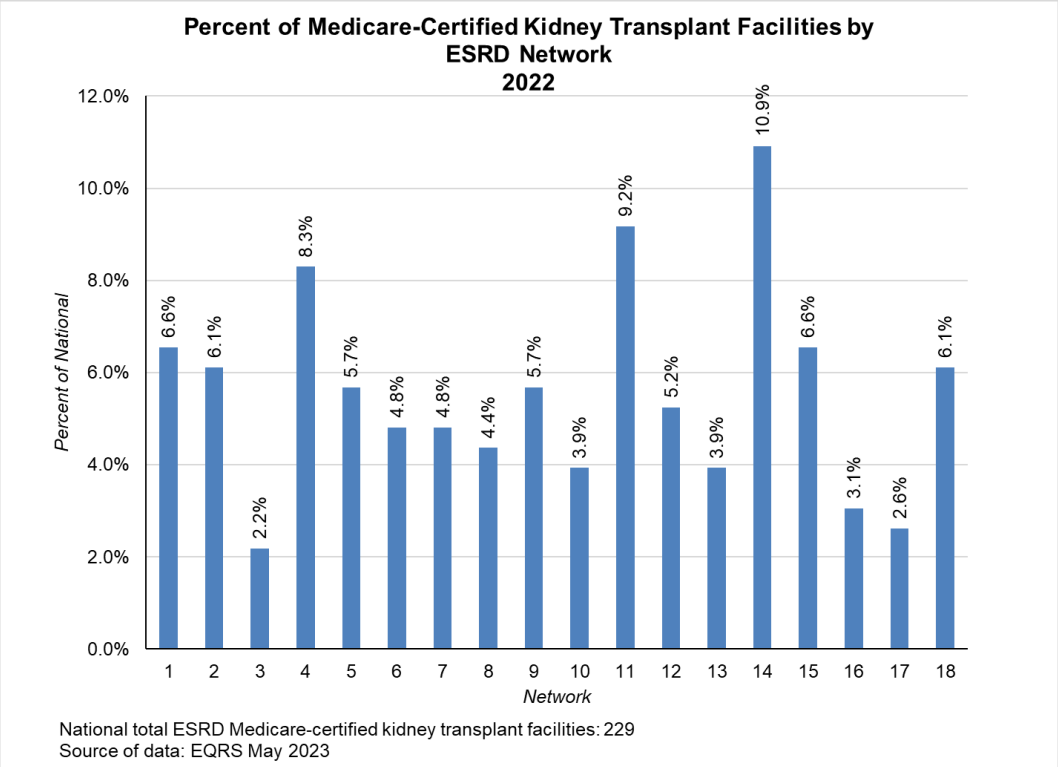


Figure 9 - Percent of Medicare-Certified Kidney Transplant Facilities in Each Network Service Area as of 12/31/2022

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ESRD Network Grievance and Access to Care Data

The ESRD Network contract states the following in Section **C.5.3 Improve the Patient Experience of Care by Resolving Grievances and Access to Care Issues**:

"*The Network has the responsibility to assist patients and dialysis facilities to resolve concerns in a manner that is satisfactory to all parties, as possible. 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 consider the management of grievances to be one of the top priorities of the work we conduct with our patients and providers. Patients, their family members and/or their representatives, have the right to file a grievance when they feel the quality of care provided to themselves or their loved ones does not meet CMS standards of care based on the ESRD Conditions for Coverage. We ensure that all of the dialysis providers in our service area are aware of the patients' right to file a grievance with us either anonymously or with consent of the patient to disclose their identity.

We developed and provided a flyer to all patients that outlined these rights. We e-mailed these flyers to each dialysis facility in August 2022 and required that a facility staff person attest to distribution to all their patients. This ensured that each dialysis patient was educated in 2022 on their right to file grievances. We also provided in-person and virtual in-services designed to educate facility staff on the conditions for coverage and the IVD/IVT process.

We employ trained social workers 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. It is our practice with all grievance recommendations to emphasize patients' participation in their individualized plan of care team meetings to review treatment, life plan and further discuss questions and concerns.

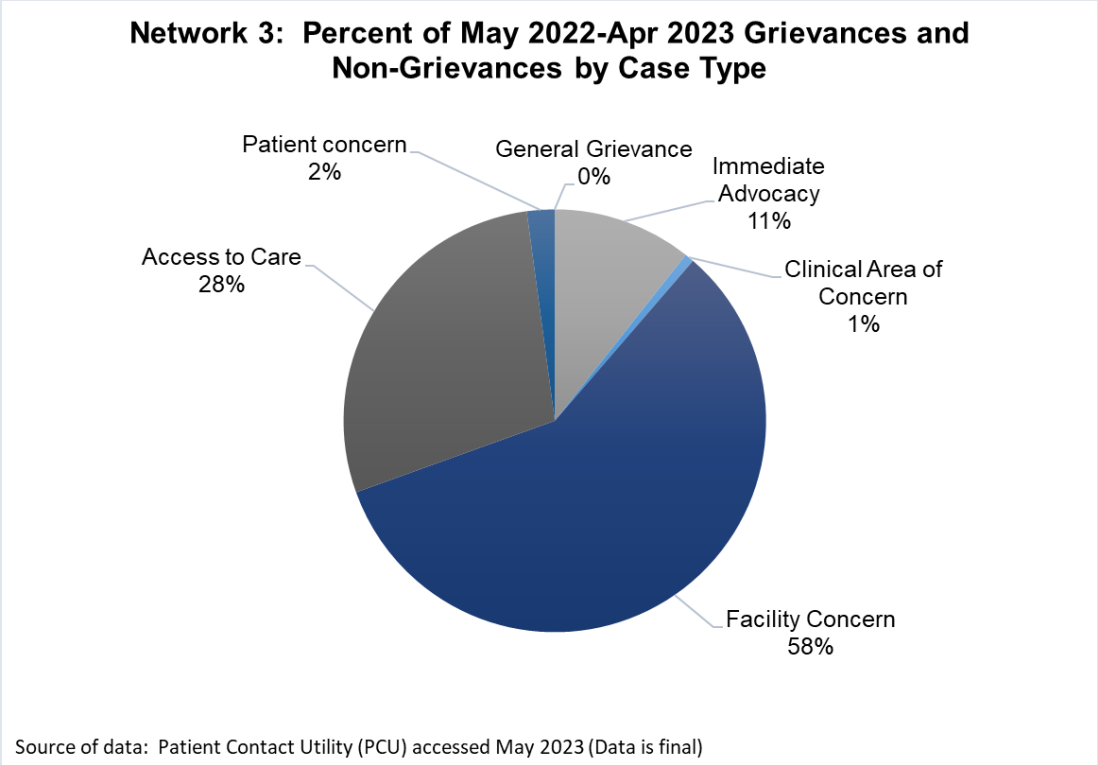
From May 2022-April 2023 we received 15 calls during which we could provide immediate advocacy. These cases included treatment related/quality of care issues, staff-related issues, other personal conflict and physical environment concerns.

We are also responsible for addressing Access to Care cases with our providers. From May 2022 – April 2023 we had 43 access to care cases that included Involuntary Discharge (IVD) cases, Involuntary Transfer (IVT) cases, and Immediate Severe Threat cases, as well as patients At-Risk for IVD/IVT. In total, we had 12 IVDs and 31 IVD cases were averted. Of the 12 IVDs 9 were Immediate Severe Threats, 1 Non-Payment, 1 Facility Unable to Meet Medical Needs and 1 Ongoing Abusive Behavior. If the 12 IVDs, six patients were placed in another dialysis facility, 1 expired and 5 continue to receive treatment in hospital emergency departments and are considered "failure to place" (F2P). The F2P cases involved patients who were discharged from their outpatient dialysis facility because of immediate severe threats, and non-payment. Our practice is to follow up with F2P cases for a period of one year to allow for our continued support of the patient and case managers at the admitting hospitals. Our efforts are focused on advocating for patients' placement at dialysis centers and/or hospital-owned outpatient dialysis facilities near the patient's home. The New Jersey Department of Health approved our use of the Fresh Start/2nd Chance Program this year for patients who have been challenging to place and is referenced while working to place the F2P cases.

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. From May 2022-April 2023, we fielded 82 Facility Concerns calls and 3 Patient Concern calls.

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 10 - Percent of Grievance and Non-Grievances by Case Type (May 2022-April 2023)

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Transplant Waitlist & Transplanted May 2022-April 2023

Goals of the QIA: Achieve a 5% increase in the number of patients added to a kidney transplant waiting list, from a baseline of 865 to a goal of 908. Achieve a 6% increase in the number of patients receiving a kidney transplant from a baseline of 604 to a goal of 640.

Results: We successfully met and exceeded both the kidney transplant waitlisting and transplantation goals as shown in figures 11 and 12. ESRD facilities in Network 3 added 1,071 patients to a transplant waitlist and transplanted 825 dialysis patients. Additionally, transplant centers in Network 3 performed 111 preemptive transplants (i.e. for ESRD patients who have not yet begun dialysis) in this period, which are not included in the count of 825 measured in this QIA. These successes are the result of comprehensive strategies implemented and collaborative efforts with dialysis facilities and transplant centers during this performance year.

Interventions: We convened a multidisciplinary advisory committee, discussed several key barriers, and recommended strategies to increasing transplant waitlisting and transplantation. Utilizing a data driven approach, we launched the Quality Insights ESRD Facility QIA Dashboard and ESRD Facility Report to provide facilities with performance metrics and actionable insights for quality improvement. To closely monitor waitlisted patients' status and ensure timely follow-up, we provided patient-level Dialysis Facility and Transplant Center Waitlist Reports. We encouraged the use of the Institute for Healthcare (IHI) Model for Improvement methodology, 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 implement and evaluate test of change. We recommended implementing the ESRD NCC Transplant Change Package, which offers comprehensive resources and guidelines for improving kidney transplantation outcomes.

We developed a comprehensive guide called "*Things to Consider When Choosing a Transplant Center*", that provided patients with essential information to help them make informed decisions about their transplant center selection. We also created a resource "*Staying Ready for Your Transplant*," that offered guidance to patients on how to prepare themselves for a potential transplant opportunity. To enhance patients' understanding of Kidney Donor Profile Index (KDPI) scores, we promoted informative handouts and posters. These resources aimed to clarify the significance of KDPI scores in kidney transplantation. These materials were developed in both English and Spanish. To further amplify the patient voice and provide inspiration, we promoted the virtual poster *Patient Voices: My Kidney Transplant Experience*. This poster featured stories of real patients who had undergone kidney transplantation, sharing their personal journeys and experiences.

In addition, we highlighted the significance of the Network Transplant QIA Website and the Transplant Designee Hub as accessible platforms to provide a centralized resource for patients and dialysis staff to access information, guidance, and support throughout the transplant journey.

To promote knowledge sharing and professional development, we presented on "*The Role of the Transplant Designee*" at two Transplant Designee Symposiums in September and October 2022, one at Virtua Our Lady of Lourdes Transplant Center in Camden, NJ and at the Penn Transplant Institute in Philadelphia, PA. We recognize the importance of health equity; we recommended incorporating strategies addressing health literacy during the transplant process to ensure equitable care for all patients.

In an effort to highlight best practices and facilitate learning, we organized a webinar featuring a high-performing facility in waitlisting and transplantation. This webinar provided insights and strategies that other facilities could adopt to improve their transplant outcomes.

We continued to work closely with transplant centers such as Cooperman Barnabas Medical Center Kidney Pancreas Transplant Center, Hackensack Meridian Health Transplant Center, Virtua Our Lady of Lourdes Transplant Center, Penn Transplant Institute and Auxilio Mutuo Transplant Center.

Collaboration with various stakeholders was crucial in our efforts to foster knowledge exchange and collaboration among professionals and organizations. Among these are the National Kidney Foundation (NKF) NJ/PA, SANOFI, and Care Dx.

Identified Best Practices: Among the best-identified practices identified were maintaining certified transplant designee/s that lead transplant activities at the dialysis facilities, early and timely provision of patient education and the availability of patient level reports to both dialysis facilities and transplant centers. The transplant designee is a required role by the state of New Jersey and has been voluntarily adopted by many dialysis facilities in Puerto Rico. The patient level reports served as a check and balance tool between patients, dialysis facilities, and transplant centers, that helped streamline communication and facilitate necessary actions.

Figure 11 – Number of Patients added to a Kidney Transplant Waitlist, cumulative (May 2022 – April 2023)

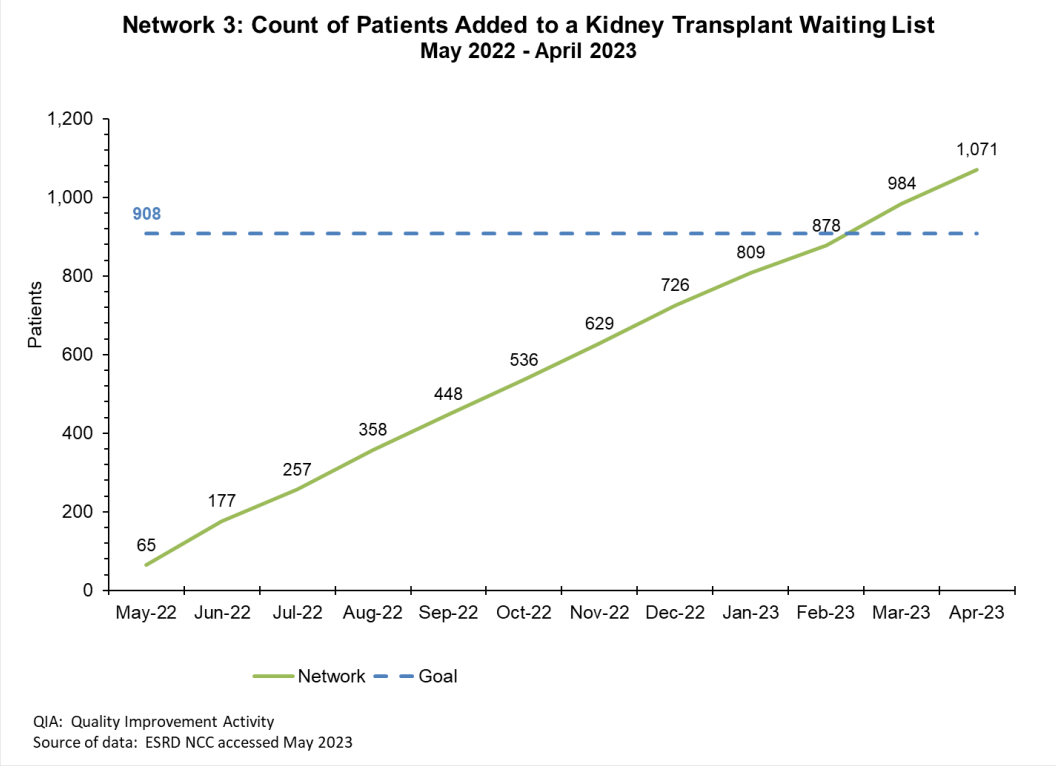
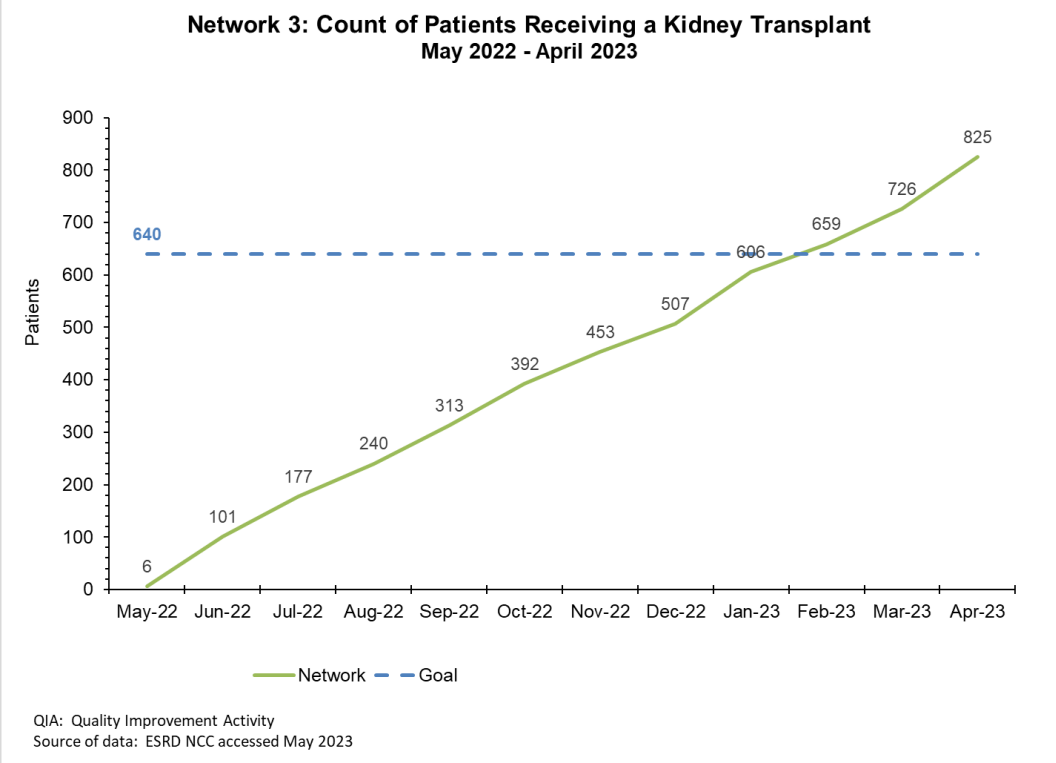


Figure 12 – Number of Dialysis Patients Receiving a Kidney Transplant, cumulative (May 2022 – April 2023)



Home Therapy May 2022-April 2023

Goal of QIA: Achieve a 2% increase in the number of prevalent ESRD patients moving to a home modality from baseline to the end of the performance period. Achieve a 10% increase in the number of incident ESRD patients who start dialysis using a home modality. The goals were to add 595 incident and 800 prevalent patients to a form of home dialysis in this project period.

Results: As shown in figures 13 and 14, providers in the Network 3 service area consistently added incident and prevalent patients to a form of home dialysis. However, we did not meet the CMS goals. Only 518 incident patients began dialysis at home and 728 patients transitioned from in-center to a home modality.

Interventions: We engaged a multidisciplinary advisory committee to gather barriers and recommended best practices for increasing home dialysis. We implemented a data driven approach to promote improvement to all facilities in the Network service area. An ESRD Facility Report dashboard was launched at the onset of the performance period. All facilities in the Network service area were given access to this dashboard. The dashboard included the home dialysis measures and Network assigned goals. Monthly updates supported rapid cycle improvement at the facility level. Facilities were encouraged to engage the interdisciplinary team and work together to develop action plans to address the barriers to increasing home dialysis. We encouraged use the Institute for Healthcare (IHI) Model for Improvement methodology, 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 implement and evaluate tests of change. Physicians received a feedback report that included their new start patient modality rates for 2021 and a copy of the QIRN3 *Patient Voices Poster: My Home Dialysis Experience*. The poster includes links to patient testimonials about their experience on a home modality. Physicians were encouraged to display the poster in their office waiting room to inspire interest and conversations about modality options by CKD patients and families.

High performing facilities presented their promising practices during coalition-led calls and participated in national expert team calls. We offered a Quality Improvement Activity (QIA) bulletin that highlighted solutions for facility frequently reported barriers. We engaged facilities for technical assistance through one on one calls, group calls, virtual and or in person visits during which we provided coaching and guided them to resources. We collaborated with patients and renal community stakeholders to offer educational events for both patients and staff.

Identified Best Practices: Among the best practices identified were the implementation of transitional care units and the funneling of new admissions through the home program. The latter included a trial period where the patient dialyzed one on one in the home program area of the facility. During the trial period, the interdisciplinary team educated the patient and family on modality options, assessed for needs and suitability for a home modality, and dialyzed the patient using a home hemodialysis machine and prescription. Two facilities in the Network service area that implemented this model exceeded their Network assigned goal for increasing home dialysis and ranked highest in the Network for the improvement achieved.

Barriers: We observed a decline in new ESRD starts that reduced the opportunities for upstream education. Staffing turnover continued to be a barrier at the facility level that impacted our efforts to engage facilities in quality improvement activities. We learned of a number of facilities that consolidated home programs and or reduced operations. At the patient level, inadequate housing and lack of family support were the social determinants of health barriers of most impact.

Figure 13 – Incident Patients Starting Dialysis Using a Home Modality, cumulative (May 2022 – April 2023)

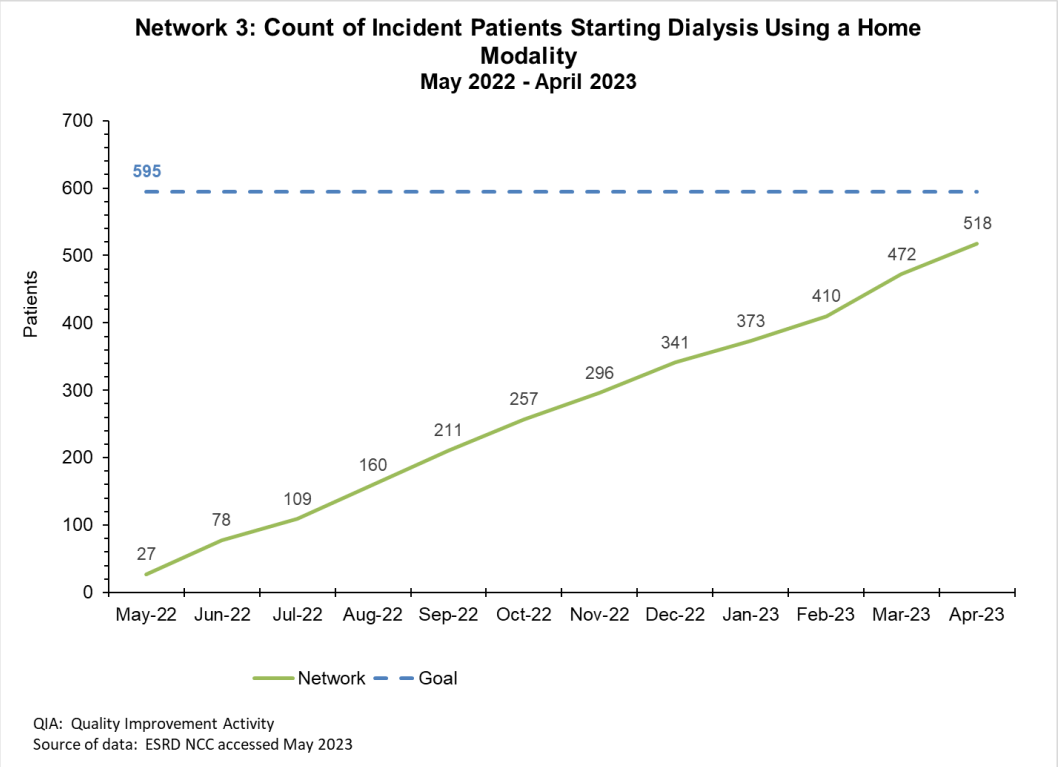
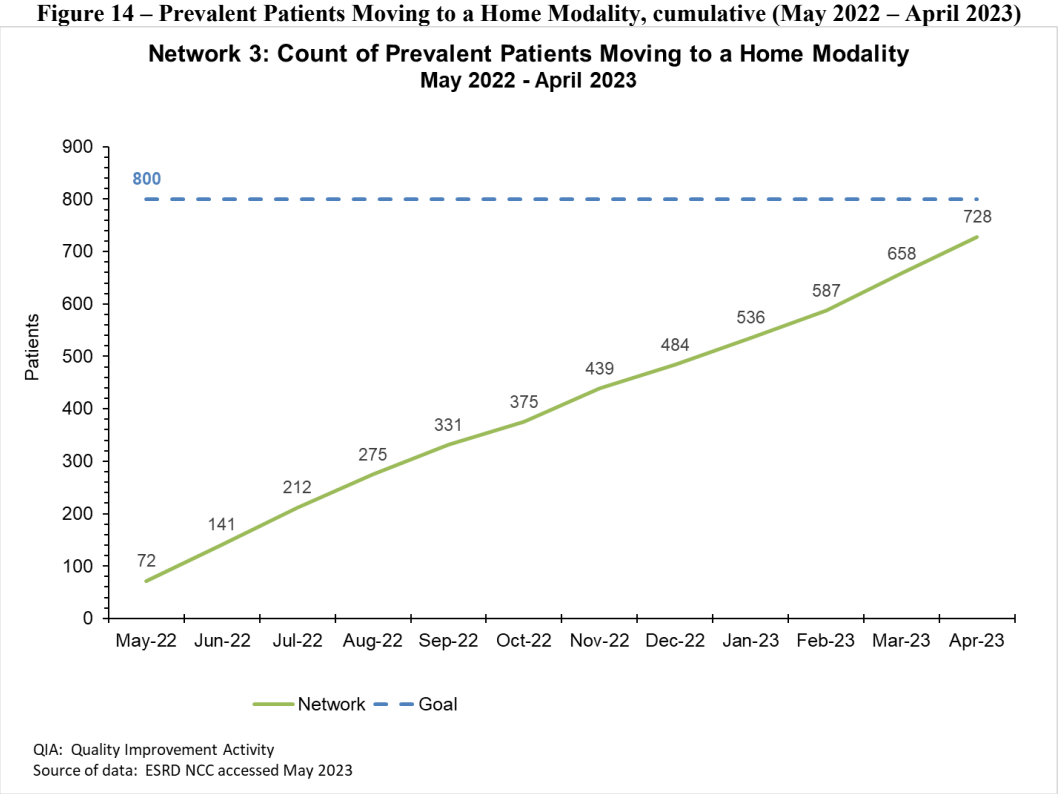


Figure 14 – Prevalent Patients Moving to a Home Modality, cumulative (May 2022 – April 2023)



Influenza Vaccinations (Patients and Staff) May 2022-April 2023

Goals of the QIA: Ensure that 90% of dialysis patients received an influenza vaccination based on data from EQRS (End-Stage Renal Disease Quality Reporting System). Ensure that 90% of dialysis facility staff receiving influenza vaccinations based on data from NHSN (National Healthcare Safety Network).

Results: As indicated by figures 15 and 16, facilities in the Network 3 service area did not meet the goals in either of these measures.

Interventions: We convened a multidisciplinary advisory committee, discussed several key barriers, and recommended strategies to increase vaccination uptake. Utilizing a data driven approach, we launched the Quality Insights ESRD Facility QIA Dashboard and ESRD Facility Report to provide facilities with performance metrics and actionable insights for quality improvement. To assist facilities validate data reported in EQRS, patient level reports for the influenza vaccination were provided. We encouraged the use of the Institute for Healthcare (IHI) Model for Improvement methodology, 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 implement and evaluate test of change.

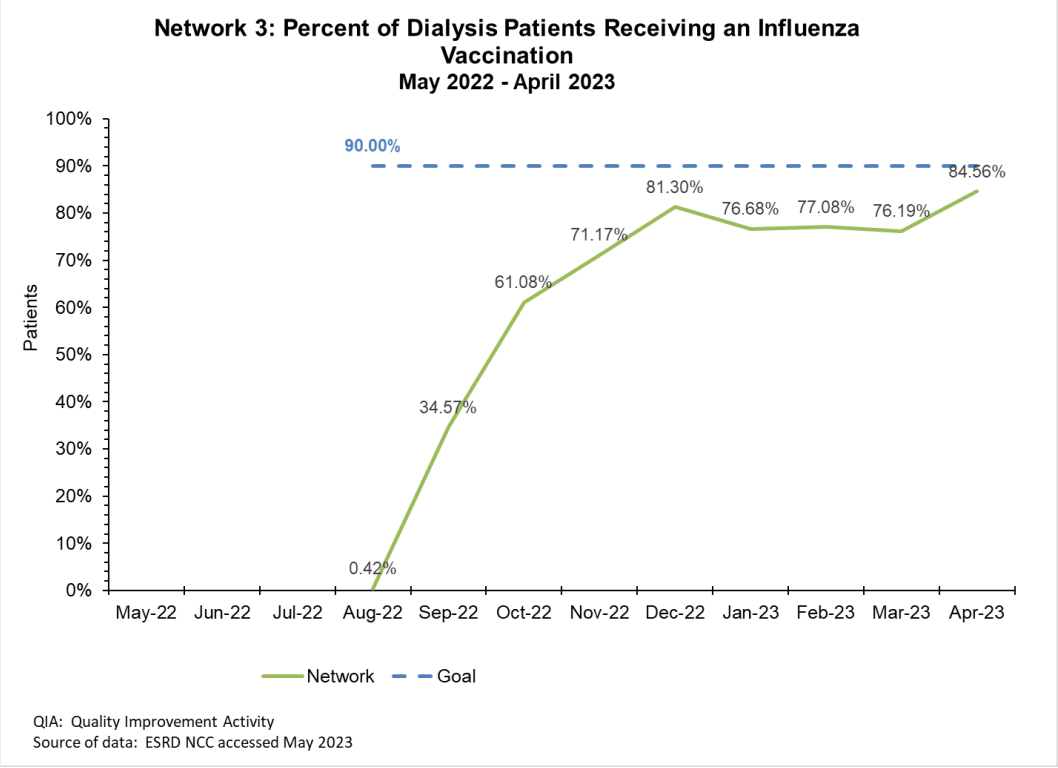
We recommended implementing the ESRD NCC Vaccinations Change Package, which offers comprehensive resources and guidelines for increasing vaccination uptake. We supported facilities through distribution of staff and patient focused educational materials from reliable sources such as the Centers for Disease Control and Prevention (CDC), the New Jersey, Puerto Rico and US Virgin Islands Department of Health, the American College of Physicians and the Immunization Action Coalition. The materials addressed misconceptions about the flu vaccine, dispelling myths and recommended approaches to vaccine hesitancy. We promoted effective conversation strategies to engage patients in discussions about vaccinations, considering their individual perspectives and concerns. In addition, we highlighted the significance of the Network Vaccinations QIA Website as accessible platforms to provide a centralized resource to access information that includes data reporting guidance. During the National Immunization Month in August, we re-launched the 2022-2023 Vaccination Olympics Campaign to continue raise awareness and promote the benefits of vaccination. Additionally, CDC updates on influenza activity during the season were shared with facilities whose vaccination rates were below 90%, emphasizing the importance of vaccinations during periods of high flu activity.

We conducted best practices webinars in English and Spanish where facilities that achieved the highest vaccination rates during the base year period shared successful strategies and fostered peer learning. Educational opportunities offered by stakeholders were promoted; ensuring facilities had access to the latest information and resources. As influenza vaccination data reporting transitioned from the clinical module to the patient module in EQRS in 2022, we provided technical assistance to facilities navigating through the change.

Identified Best Practices: Interdisciplinary team approach, organized planning, systematic monitoring and tracking were the identified best practices in vaccinations.

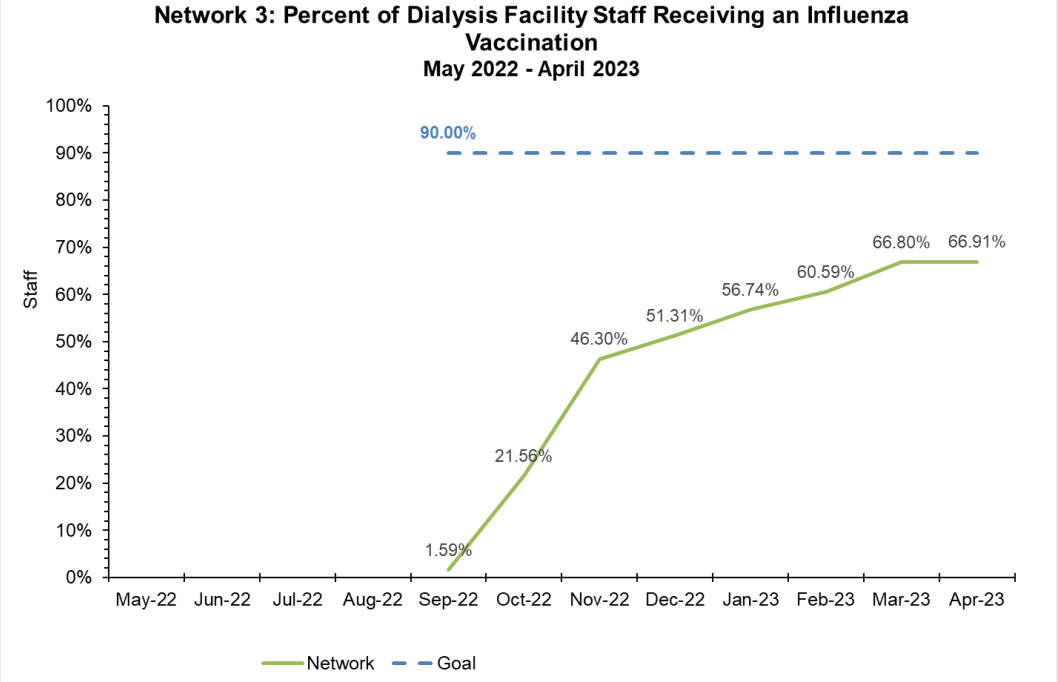
Barriers: As the COVID-19 pandemic continued to prevail, the heightened campaign to receive up to date COVID-19 vaccines coupled with required masking, patients and staff experienced vaccine fatigue and minimized value of receiving flu vaccine. Facility staff turnover, lack of backup EQRS user and competing priorities played a role as well in addition to data integrity and reporting issues. There were patients vaccinated outside the facility that were unable to present their vaccination record. Finally, allowing Fresenius and DaVita to electronically submit staff vaccination numerators and denominators to NHSN resulted in widespread data inaccuracies such as staff counts attributed to facilities that exceeded the actual number of staff employed at the facilities.

Figure 15 – Percent of Patients Receiving an Influenza Vaccination, 2022-2023 Flu Season



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2023

Figure 16 – Percent of Dialysis Facility Staff Receiving an Influenza Vaccination, 2022-2023 Flu Season



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2023

COVID-19 Vaccinations (Patients and Staff) May 2022-April 2023

Goals of the QIA: Ensure that 80% of dialysis patients receive an initial COVID-19 vaccination and/or vaccination series, and that 80% of fully vaccinated dialysis patients receive any additional CDC and/or CMS recommended COVID-19 vaccinations based on data from the National Healthcare Safety Network (NHSN). Ensure that 100% of dialysis facility staff receive an initial COVID-19 vaccination and/or vaccination series, and that 100% of fully vaccinated staff receive any additional CDC and/or CMS recommended COVID-19 vaccinations based on data from NHSN.

Results: We achieved 80% of dialysis patients receiving the COVID-19 primary series. We attribute this success mostly to the extraordinary efforts demonstrated by the facilities in Puerto Rico. However, we did not meet the goal for fully vaccinated dialysis patients to receive any additional CDC and/or CMS recommended COVID-19 vaccinations, the goals for dialysis facility staff to receive an initial COVID-19 vaccination and/or vaccination series and fully vaccinated dialysis facility staff to receive any additional CDC and/or CMS recommended COVID-19 vaccinations.

Interventions: We met with a multidisciplinary advisory committee to address multiple barriers and devise strategies to boost vaccination rates. By employing a data-oriented approach, we introduced the Quality Insights ESRD Facility QIA Dashboard and ESRD Facility Report. These tools provide facilities with performance metrics and actionable insights to facilitate quality improvement.

To promote effective quality improvement, we advocated for the utilization of the Institute for Healthcare (IHI) Model for Improvement methodology. This involved employing root cause analysis (RCA), creating facility-specific quality improvement plans, and implementing the Plan-Do-Study-Act (PDSA) cycle(s) to test and evaluate changes.

We recommended incorporating the ESRD NCC Vaccinations Change Package, an extensive resource that provides guidelines to improve vaccination rates. In order to assist facilities, we actively promoted educational opportunities that provided the most up to date information and resources available. We distributed materials sourced from credible institutions such as the CDC, the Department of Health in New Jersey, Puerto Rico, and the US Virgin Islands, the American College of Physicians, and the Immunization Action Coalition. These resources aimed to address misconceptions about the COVID-19 vaccine, dispel myths, and offer guidance on how to tackle vaccine hesitancy.

We promoted effective conversation strategies to engage patients in discussions about vaccinations, considering their individual perspectives and concerns.

In observance of National Immunization Month in August, we reintroduced the Vaccination Olympics Campaign for the 2022-2023 period, to sustain raising awareness and advocating for the benefits of vaccination.

We held best practices webinars in English and Spanish featuring facilities that achieved the highest vaccination rates during the base year period. These webinars served as platforms for sharing successful strategies and fostering peer learning among participants. Furthermore, we actively promoted educational opportunities provided by stakeholders, ensuring that facilities had access to the most up-to-date information and resources available.

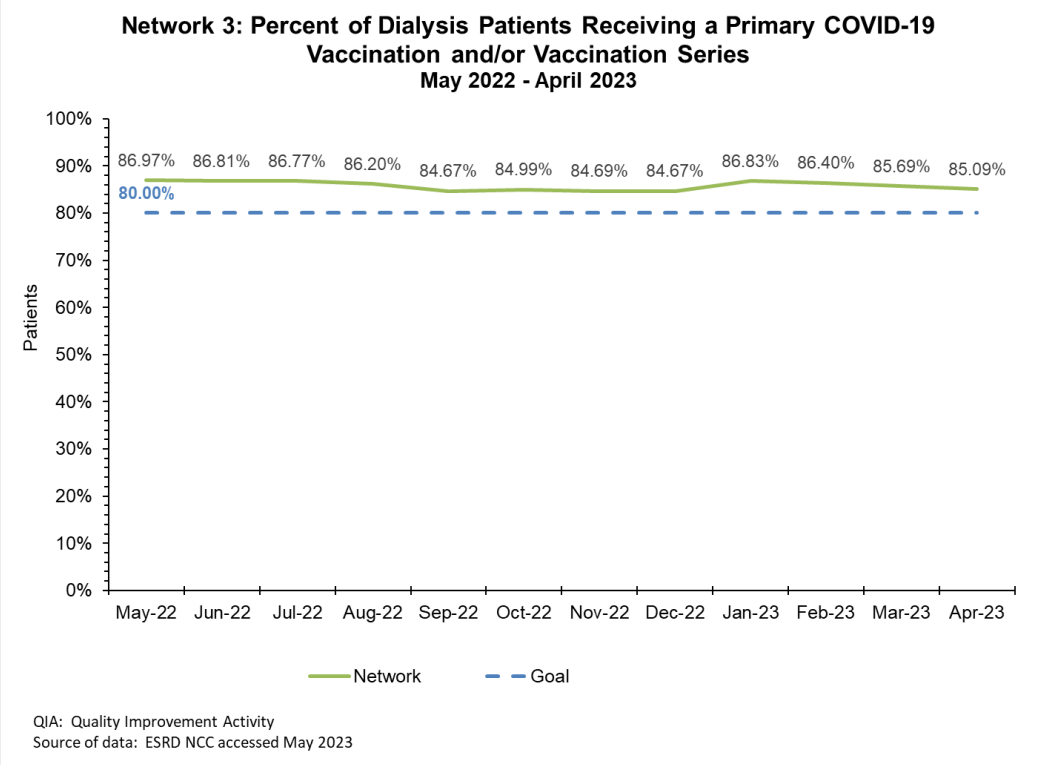
We provided technical assistance to facilities that included one-on-one support calls responding to vaccination data validation and data discrepancies between internal records and NHSN data, addressing staff turnover and competing priorities. We guided facilities to rectifying information in their respective EMR systems utilizing their respective organization’s provided direction.

We supported facilities with sharing available transportation resources to bring patients to vaccination sites such as VaxRide NJ if required.

Identified Best Practices: Interdisciplinary team approach, organized planning, systematic monitoring and tracking were the identified best practices in vaccinations.

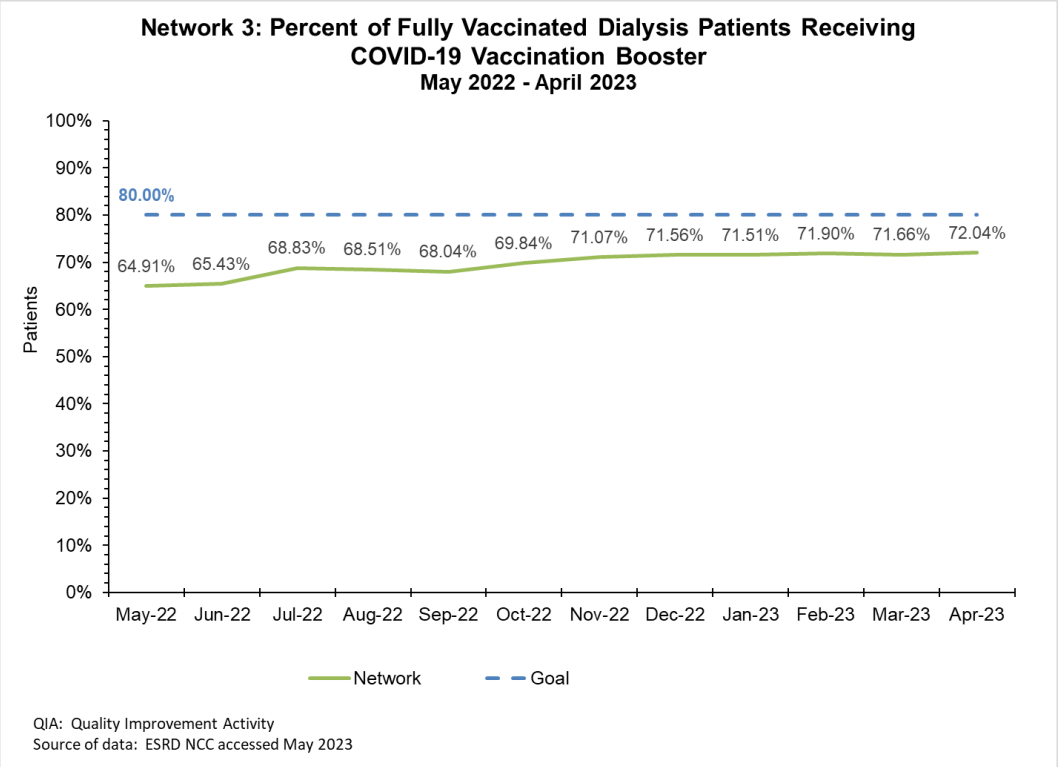
Identified Barriers: Vaccine fatigue, vaccine hesitancy, fear of side effects and data integrity were the barriers identified for this performance year. COVID-19 virus was perceived less of a threat by many because of significantly reduced media coverage noted in 2022. There were patients who received vaccinations outside the facility, but who faced challenges in providing proof of vaccination. As reported in the influenza vaccination QIA above, we found that staff counts attributed to facilities were more than actual numbers in this QIA as well. Organizations (Fresenius and DaVita) that "batched" or electronically submitted data to NHSN had data integrity issues. We will work to build stronger partnerships with corporate quality leads to provide support at the facility level.

Figure 17 – COVID Vaccination Rate (Dialysis Patients)



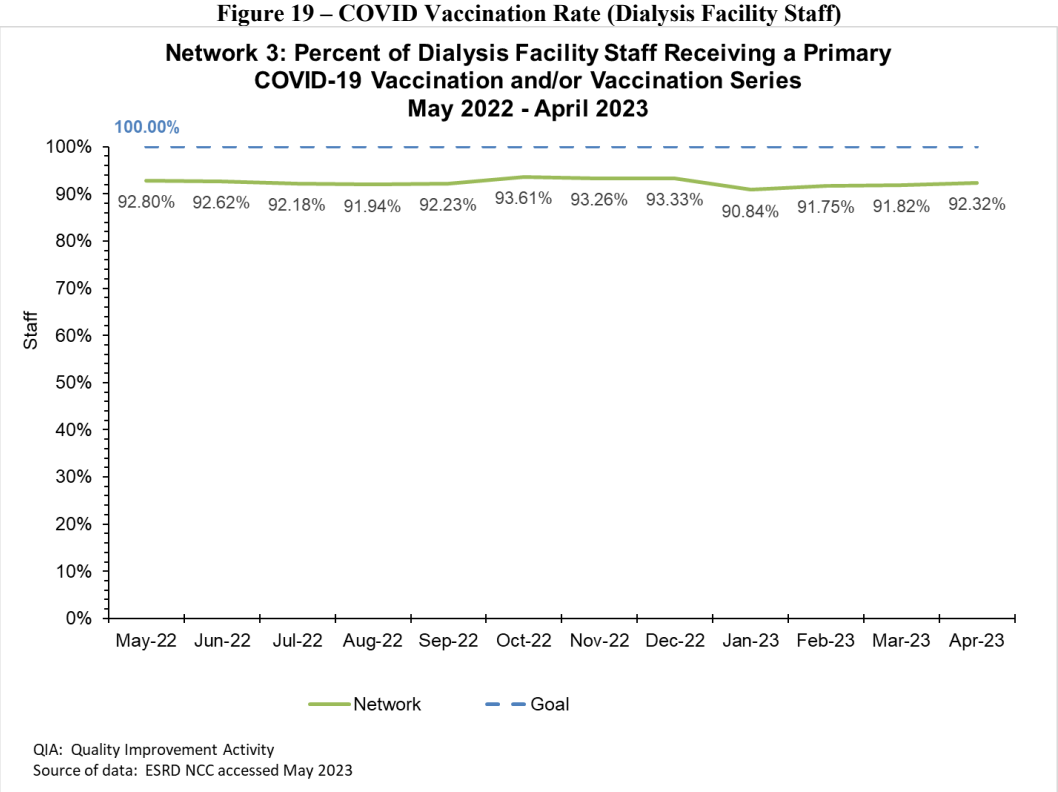
QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2023

Figure 18 – Percent of Fully Vaccinated Dialysis Patients Receiving COVID Booster



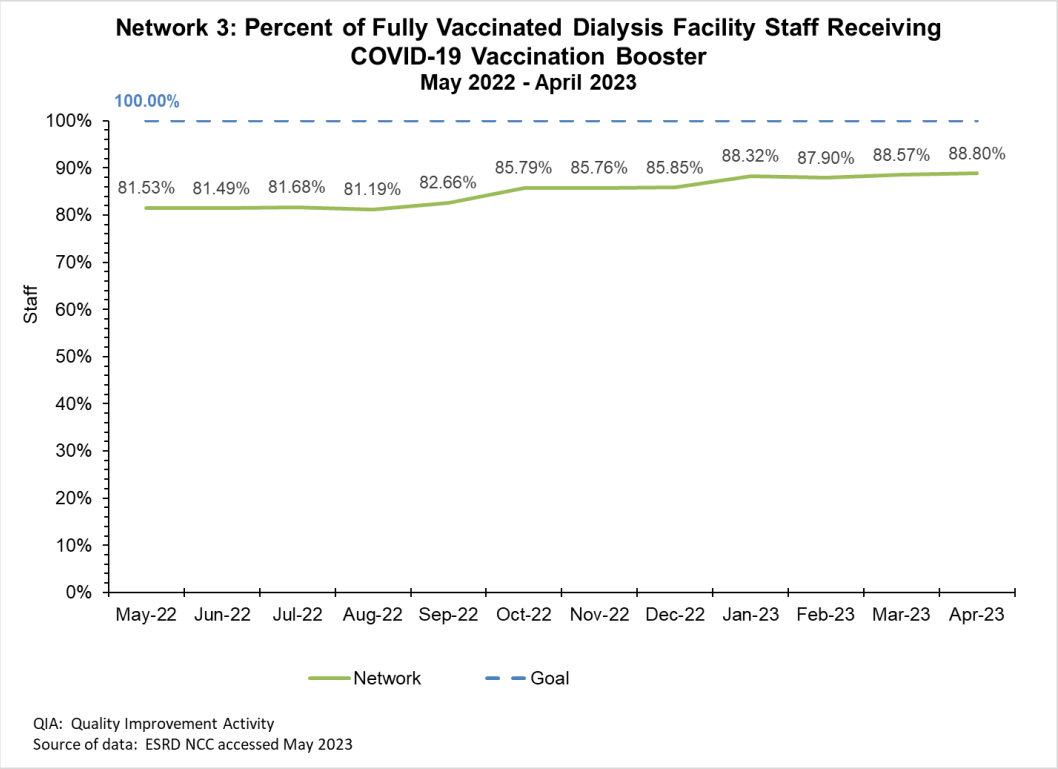
QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2023

Figure 19 – COVID Vaccination Rate (Dialysis Facility Staff)



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2023

Figure 20 – Percent of Fully Vaccinated Dialysis Facility Staff Receiving COVID Booster



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2023

Data Quality (Admissions, CMS Form 2728, CMS Form 2746) May 2022-April 2023

Patient Admissions submitted to EQRS within 5 days of starting at facility

Goal of QIA Achieve a 5% increase in the rate of patient admission records from dialysis facilities entered within five (5) business days, from the baseline to the end of Option Period 1.

Results As seen in Figure 21, at the conclusion of the project, admission records entered within 5 days was at 76.57% which exceeded the goal of 75%

Identified Barriers

EQRS

- More instances of inability to admit dialysis after patients experienced a failed transplant
- Seeing more "possible duplicate patients" due to change in policy in EQRS where a Medicare Beneficiary Identifier is required during admission process if one already exists in the patient record (previously in CROWNWeb "NA" could be selected and the admission would be completed)
- Tickets opened with the EQRS helpdesk often are not resolved within 5-day timeframe

Electronic Data Interface (EDI) Submitters

- EDIs noting an increase in the number of near match errors (i.e. patient identifiers in submitted data do not match identifiers in EQRS)
- One EDI only batches to EQRS weekly, causing them to often miss the 5-day goal
- EDIs have never focused on "timely" patient admissions
- EDIs educate their facilities not to manually enter patients as it affects future patient mapping
- Lack of communication from EDIs with the Networks to assist in admission process

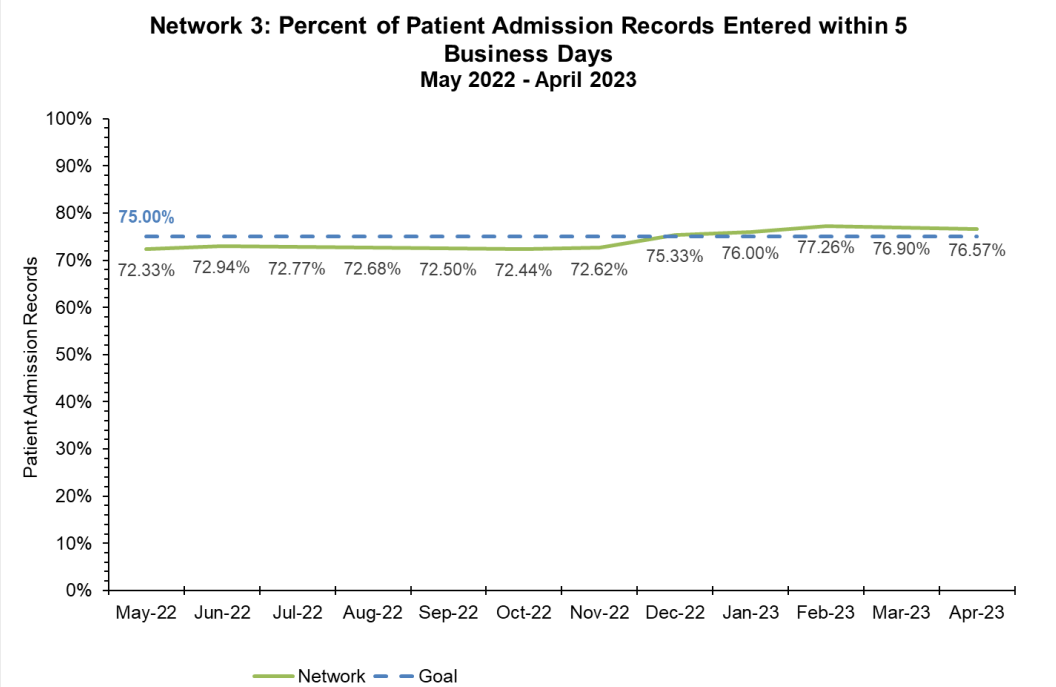
Facility Level

- Staff Turnover/no backup EQRS user
- Lack of Patient Attributes & Related Treatment (PART) verification in EQRS, so facility staff cannot easily determine which patients are considered admitted to their facility
- EDI facilities relying solely on batch for patient admissions
- EDIs educate their facilities not to manually enter patients as it affects future patient mapping, thus facilities wait weeks to months before alerting us that a patient has not been admitted

Mitigation Efforts

- The ESRD Data Managers met with EDI Submitters on several occasions to discuss specific barriers
- We sent Large Dialysis Organization (LDO)-specific EQRS educational links to facilities
- We developed several tools to assist facilities in tracking admissions including an EQRS Monthly Checklist and a caseload form. Both of these are posted on our website to be accessed easily by facilities
- We contacted low performing facilities and provided current rates and education
- We shared EOCT new user training registration information, announcements, Town Hall events and encouraged them to sign up for the communications
- We scheduled monthly educational calls with EQRS data contacts to answer their questions about EQRS

Figure 21 – Percent of Admissions Entered into EQRS within 5 Days (May 2022 – April 2023)



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2023

CMS 2728 Forms submitted within 45 Days

Goal of QIA Achieve a 4% increase in the rate of initial CMS-2728 forms submitted from dialysis facilities within forty-five (45) days.

Results As seen in Figure 22, at the conclusion of the project, initial CMS-2728 forms submitted from dialysis facilities within forty-five (45) days was at 84.9% which was below the goal of 86.7%.

Identified Barriers

EQRS

- Facility Dashboard bugs
- The Facility Dashboard is no longer the landing page for EQRS so facility staff cannot easily see which forms are outstanding

EDI Submitters

- LDOs have acknowledged that there is no emphasis places on forms timeliness
- Incorrect batch admission reasons do not trigger need for a form

Facility Level

- Nephrologists not coming in to facility regularly to sign 2728 forms
- Patients refusing to sign forms
- Incorrect admission reasons not triggering need for 2728
- No labs available within the applicable data range
- Breakdown in communication with other facilities where forms may not have been signed by the patient before transferring out
- Patients hospitalized and unable to sign form
- Admissions from foreign visitors that treat briefly; often forms are not completed within that brief time and when patient leaves there is no way of obtaining a patient signature
- Staff turnover/no backup EQRS user

Mitigation Efforts

- Our Regional Data Manager worked with the Data Manager Timeliness subgroup and EDIs to discuss ways to meet the data quality goals
- On July 12, 2022 we presented the Data Quality project to all of our facilities during our Kickoff meeting
- We began sending reports to all dialysis facility Data Contacts containing the EQRS IDs of patients with CMS forms in missing/saved status
- We targeted low performing facilities that had forms coming due, reminded them of due dates and provided technical assistance

Education

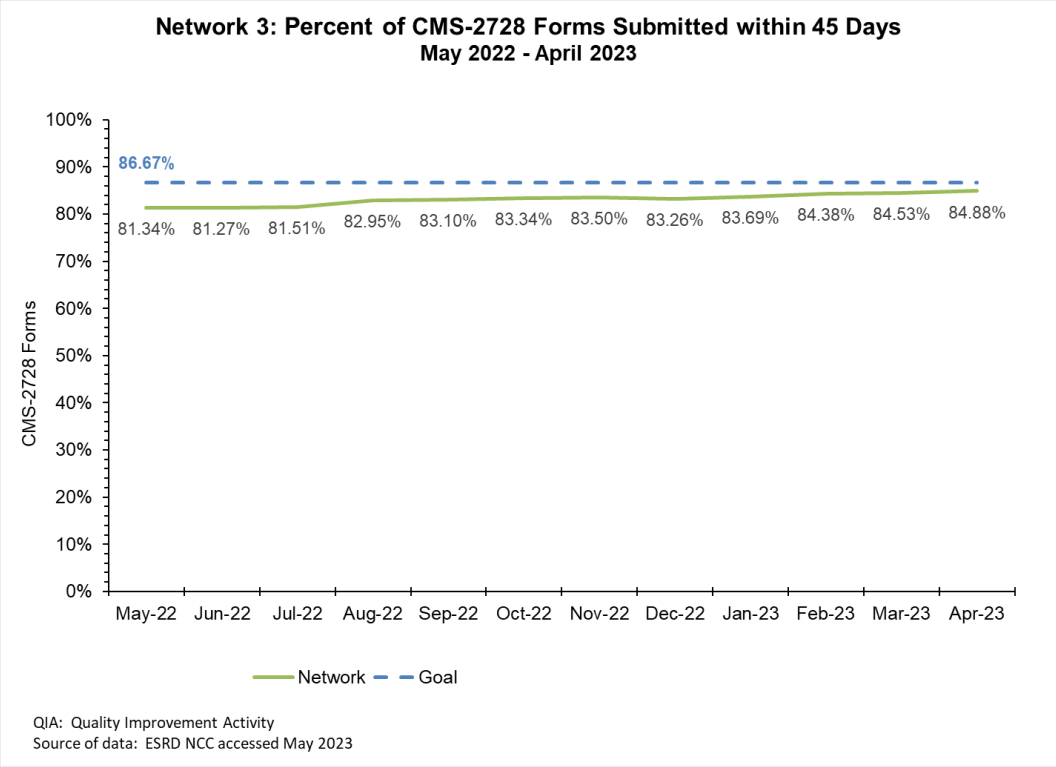
- We developed an EQRS Monthly Checklist and FAQ for the CMS 2728 (patient and facility versions) which were posted to the data section of our website. The link was shared via email with all of our facilities' EQRS data contacts

- We developed the 2728 patient version to specifically address patients' refusal to sign the form
- We reminded facilities that these forms are essential in getting patients their ESRD benefits
- We educated facilities on correct admission reasons and make sure that they were updated in their EMRs as well as EQRS
- We sent missing forms reports to facilities
- We scheduled monthly educational calls with EQRS data contacts to answer their questions about EQRS
- We shared EOCT new user training registration information, announcements, Town Hall events and encouraged them to sign up for the communications
- We sent educational information to facility medical directors explaining the importance of timely CMS forms submissions and requesting their assistance in improving forms submissions rates

Technical Assistance

- We made recommendations to facilities to involve their medical directors in getting nephrologists to sign forms in a timely manner
- We advised facilities to reach out to the patient's next of kin for assistance in obtaining a patient signature or the signature of the Power of Attorney and offering to send the form to them for signature with a self-addressed stamped envelope to return the signed forms
- We discussed the importance of having a backup person to assist with EQRS data entry and offered to provide training to new staff
- We began including the regional managers of low performing facilities in communications about late forms

Figure 22 – Percent of CMS-2728 Forms Submitted to EQRS within 45 Days (May 2022 – April 2023)



CMS 2746 Forms submitted within 14 Days of Death

Goal of QIA Achieve a 2% increase in the rate of CMS-2746 forms submitted from dialysis facilities within 14 days of the date of death from the baseline to the end of the base period.

Results As seen in Figure 23, at the conclusion of the project, admission records entered within 5 days was at 72.2% exceeding the goal of 67.6%

Identified Barriers

EQRS

- Patient page edit checks do not allow cause of death to be added (issues with duplicate Medicare statuses, effective dates)
- Disappearing Dates of Death (DOD)s, Cause of Death (COD)s and discharges; These cause the dashboard to report missing 2746 forms that have already been submitted
- Facility Dashboard bugs
- Issue that may still be impacting 2746 submissions rates using the 12 month look back: There were several months after EQRS went live that facilities could not enter 2746 forms due to duplicate Medicare statuses that can no longer be fixed by Network staff members

Facility Level

- Facilities are not informed that a patient is deceased
- Hospitals are claiming HIPAA as a reason not to provide a patient's cause of death
- Facilities are awaiting correct causes of death from physician or hospital instead of just using "unknown" or "cardiac arrest"
- Some facilities are not following patients who discontinue dialysis
- Staff turnover/Staff pulled into different roles due to COVID

Mitigation Efforts

- The Network Data Managers sought guidance from CMS regarding using Unknown as a cause of death in order to submit 2746s on time, essentially asking whether CMS preferred timeliness or accuracy. Facilities had reported to us that much of the delay in submitting 2746s could be attributed to their difficulty in obtaining the patient's cause of death from the hospitals

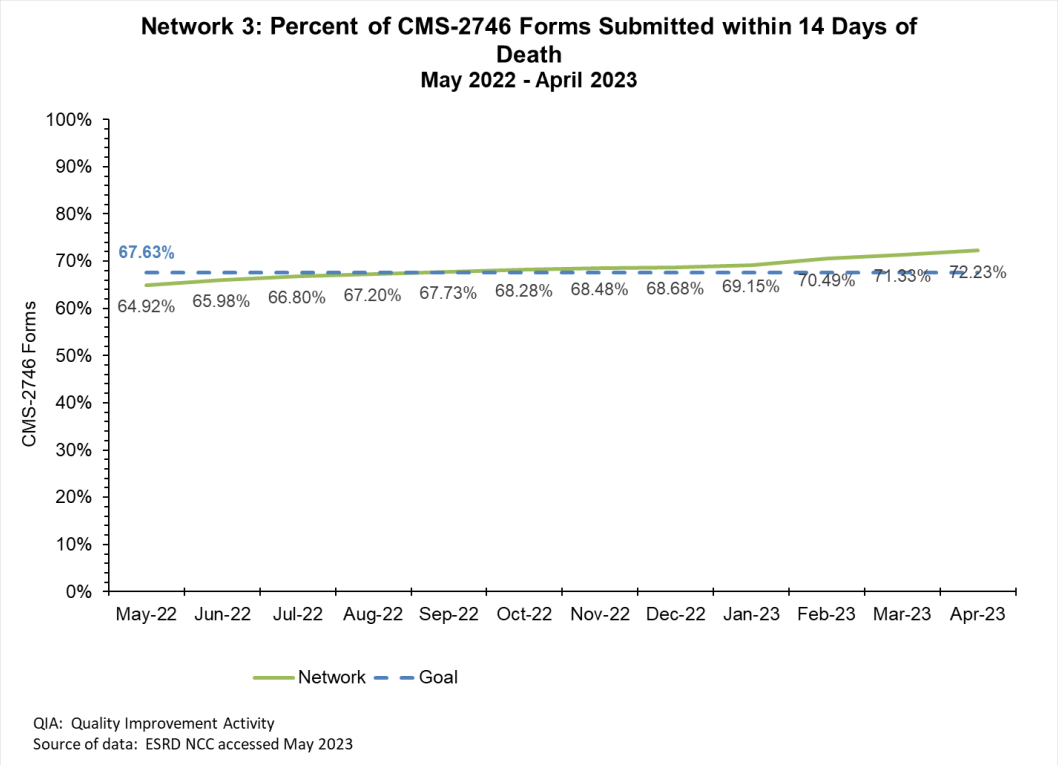
Education

- We developed an EQRS Monthly Checklist and FAQ for the CMS 2746 form which was posted to the data section of our website. The link was shared via email with all of our facilities' data contacts.
- LDO-specific EQRS educational links were sent to facilities
- We provided education to facilities regarding proper follow-up with patients who have discontinued dialysis.

Technical Assistance

- We encouraged our facilities to contact the supervisors of the medical records departments in local hospitals to see what can be done to facilitate sharing of information including using hospital medical release forms.
- We recommended having a backup person to assist with EQRS data entry and offered to provide training to new staff
- We encourage facility staff to stay in communication with patient families after a patient discontinued dialysis.
- We began sending missing/saved forms emails to facilities to assist in reminding the staff

Figure 23 – Percent of CMS-2746 Forms Submitted to EQRS within 14 Days of Death (May 2022 – April 2023)



Hospitalization (Inpatient Admissions, ED Visits, Readmissions and COVID-19 Admissions) May 2022-April 2023

Goal of QIA: Achieve a 3% decrease in the rate of hospital admissions for a diagnosis on the List of Primary Diagnosis Categories. Achieve a 4% decrease in the rate of hospital 30-day unplanned readmissions for a diagnosis on the List of Primary Diagnosis Categories. Achieve a 3% decrease in the rate of outpatient emergency department visits for a diagnosis on the List of Primary Diagnosis Categories.

Results: As shown in the following figures, we met the goal for reducing readmissions. Unfortunately, we did not meet the goal for reducing inpatient admissions, emergency department visits, and COVID-19 admissions.

Interventions: We engaged a multidisciplinary advisory committee to gather barriers and recommended best practices for reducing avoidable admissions, ED Visits. We implemented a data driven approach to promote improvement to all facilities in network service area. An ESRD Facility Report dashboard was launched at the onset of the performance period. All facilities in the network service area were given access to this dashboard. The dashboard included the home dialysis measures and network assigned goals. Monthly updates supported rapid cycle improvement at the facility level. Facilities were encouraged to engage the interdisciplinary team and work together to develop action plans to address the barriers to preventing hospital admissions and ED Visits. We encouraged use the Institute for Healthcare (IHI) Model for Improvement methodology, 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 implement and evaluate test of change.

High performing facilities presented their promising practices during coalition led calls and participated in national expert team calls. We offered a Quality Improvement Activity (QIA) bulletin that highlighted solutions for facility frequently reported barriers. We engaged facilities for technical assistance through one on one calls, group calls, virtual and or in person visits during which we provided coaching and guided them to resources.

Identified Best Practices: Among the best practices identified were the implementation of interdisciplinary team rounding which allows for routine follow up and timely intervention for needs identified, effective medication reconciliation, individualized approach to education, and post hospitalization follow up and support by dialysis staff.

Barriers: We found that hospital admissions for transplantation were included in the network data. As our transplant rates increased, the hospital events increased as well. Other diagnosis codes were comorbidities that would be included for hospital billing purposes. As a result. CMS has revised the priority diagnosis list for the future performance periods.

At the patient level, transportation was the social determinants of health barriers of most impact. Patients that lacked transportation resources would go to the ED for treatment for conditions that could have been addressed by the primary care provider, outpatient vascular access center.

Figure 24 – Rate of ESRD-Related Hospital Admissions per 100 Patient Months (May 2022 – April 2023)

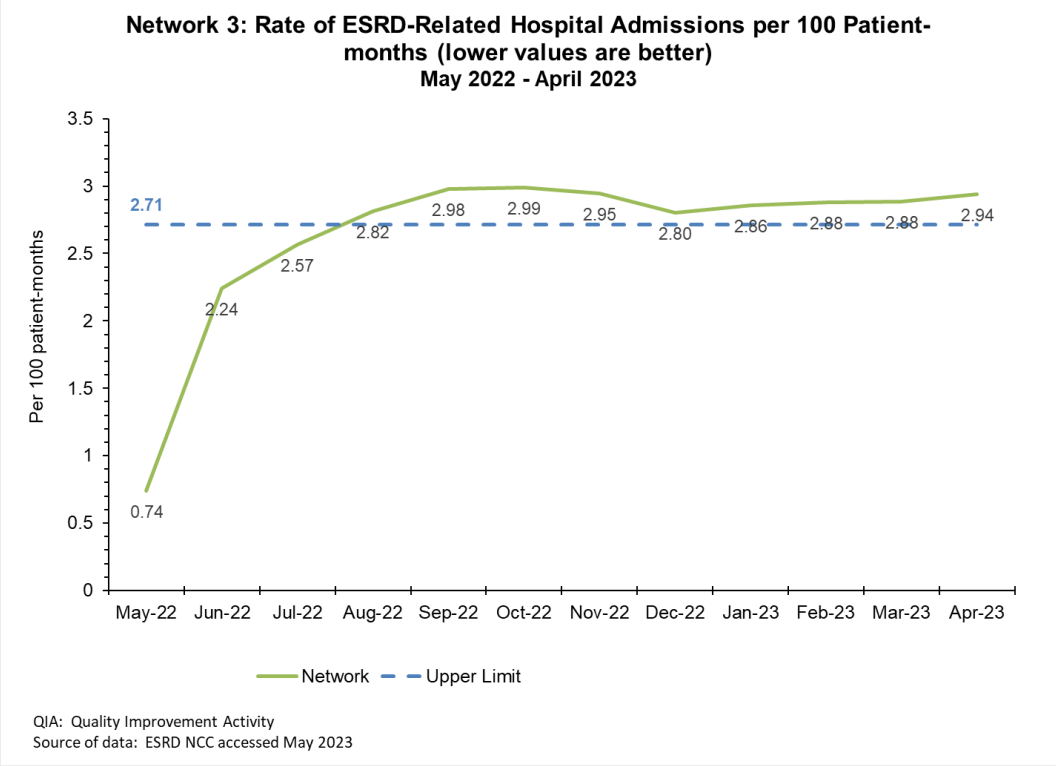


Figure 25 – Outpatient Emergency Department Visits per 100 Patient Months (May 2022 – April 2023)

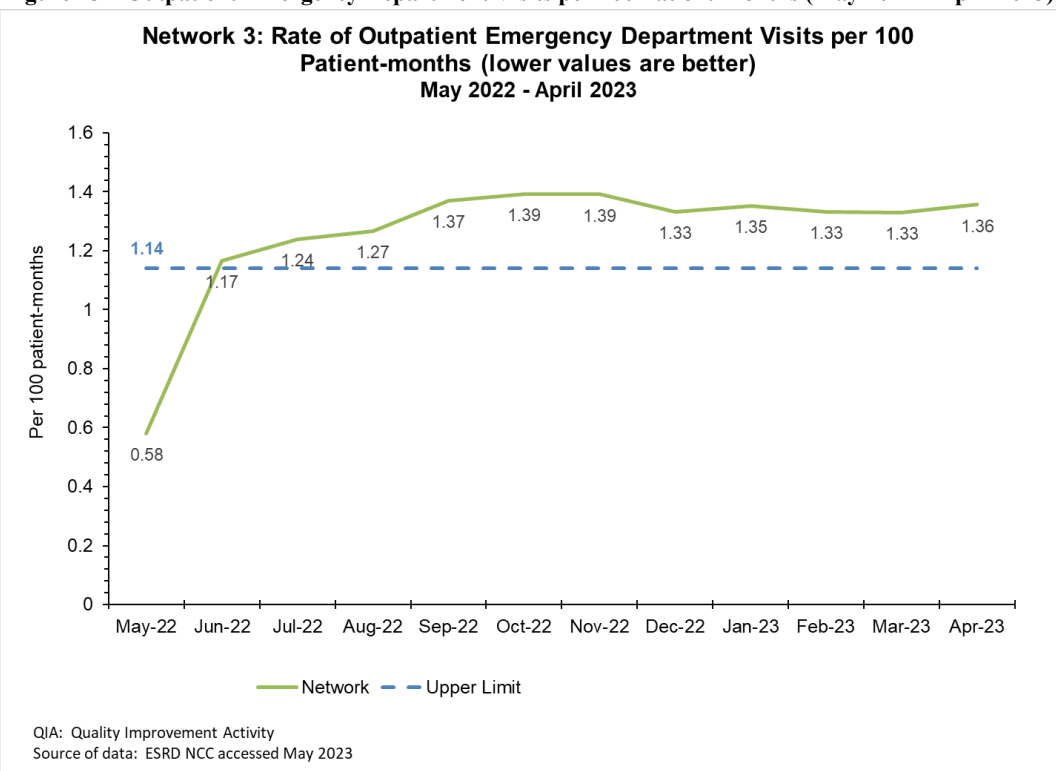


Figure 26 – Hospital 30-Day Unplanned Readmissions (as % of Hospitalizations) (May 2022 – April 2023)

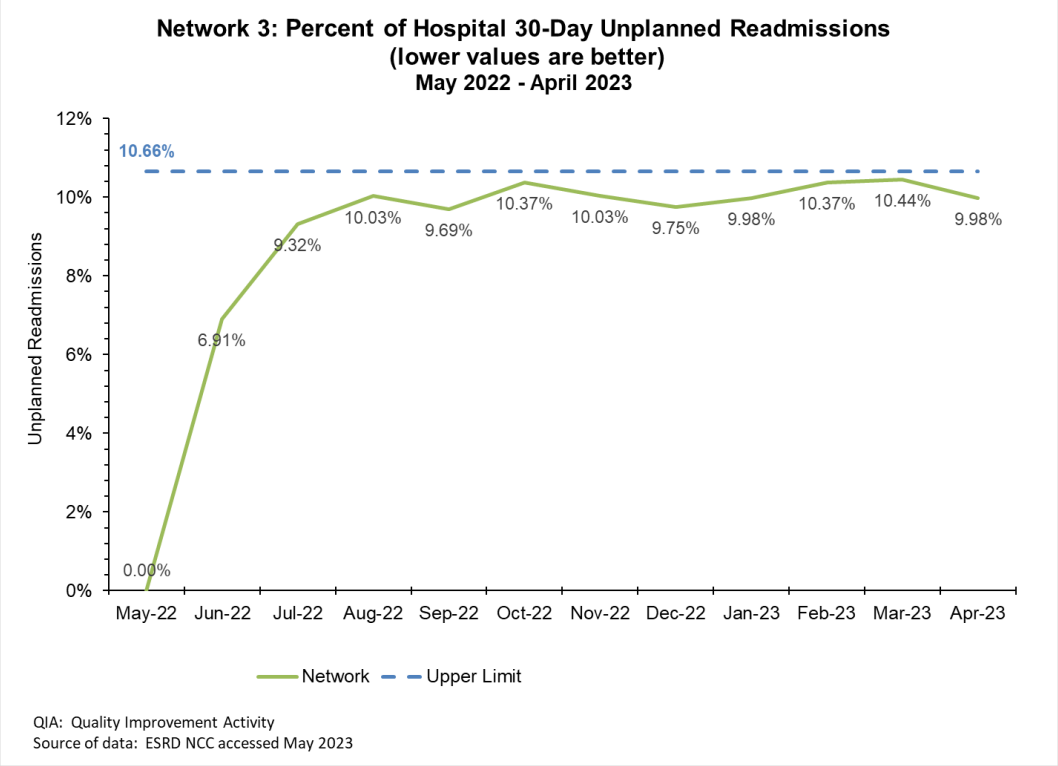
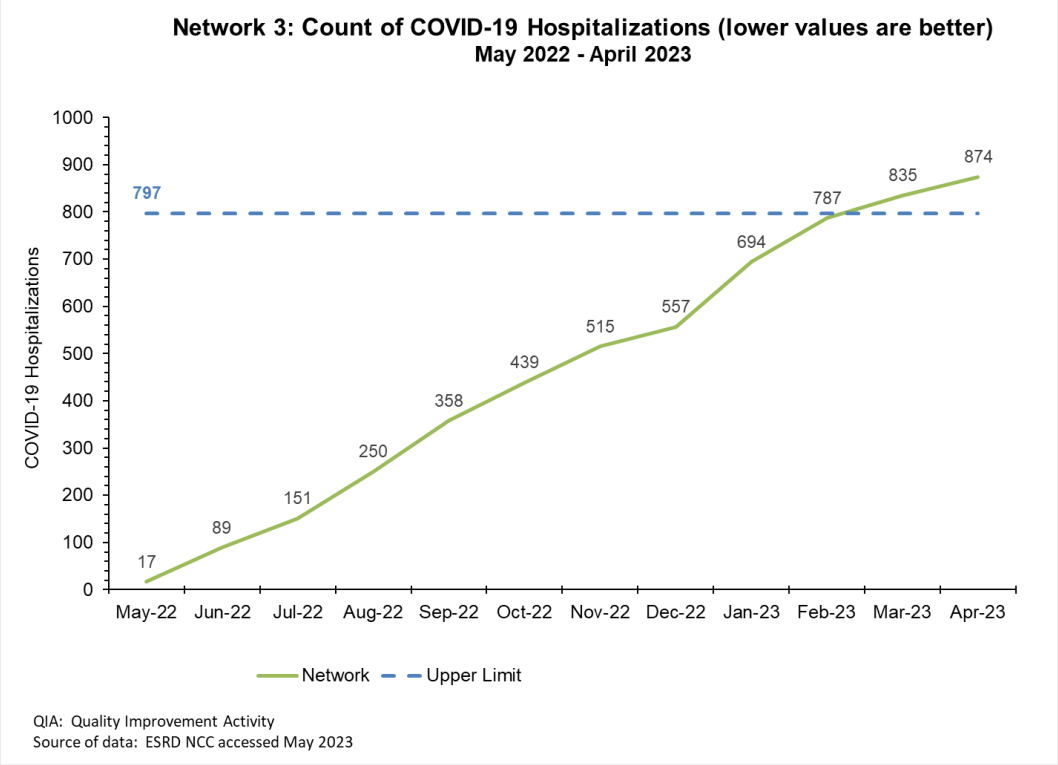


Figure 27 – COVID-19 Hospitalizations (May 2022 – April 2023, cumulative)



Depression Treatment September 2022-April 2023

Depression screening data was captured for the assessment period ending in December 2022. From the reported responses a total of 1598 patients screened positive for depression in calendar year 2022. Of the 1598, 1249 have Medicare Part B coverage and 241 were referred to a mental health provider, as detected by examining Medicare Fee For Service claims.

Social workers continue to identify lack of mental health practitioners, long wait time between calling for and being able to schedule an appointment and patient stigma around mental health as main barriers for patients seeking treatment. Reducing stigma and patient self -empowerment were the primary barriers addressed while providing technical assistance.

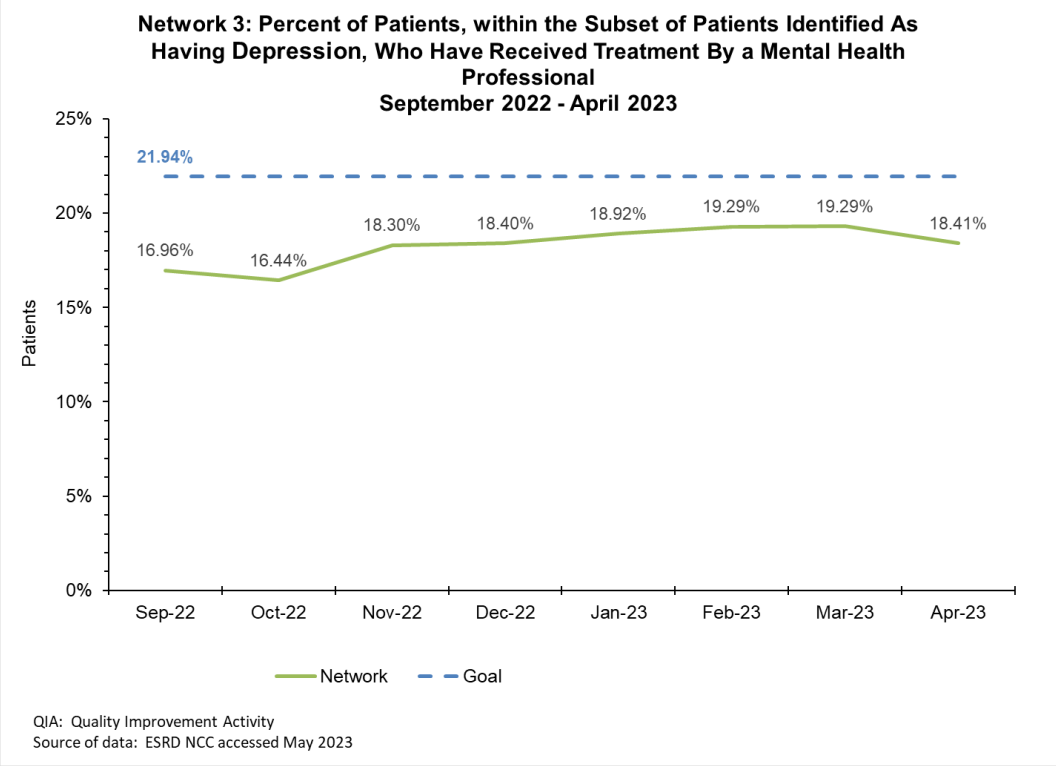
A Patient Self- Management Bulletin Board Campaign was piloted to 20 facilities in New Jersey with the goal of addressing the barriers noted above. Thirteen facilities provided feedback. All facilities responded positively to the intervention. Over 50% of the units reported patients have been more open to discussing mental health issues since implementation and have also seen a positive change in patient behavior and mood. We received positive feedback from both the social workers and the patients.

We also have identified at the facility level that social workers are engaging patients who screen positive for depression through formal behavioral health interventions within the organization as well as meeting more frequently with patients, interventions that would not be reflected in Medicare claims.

Technical Assistance was provided to all facilities who were identified as having low reporting depression screening results in EQRS. Technical assistance was provided to 8 facilities, mostly independent facilities who do not have a batch system in place for data. Barriers noted from calls were change in staff, capacity for entry and lack of training for new staff. Detailed instructions were provided on entering depression screening data into EQRS. An additional barrier noted for Fresenius reporting related to question three: screening for clinical depression documented as positive, the facility possesses no documentation of a follow up plan and no reason given- patients are initially screened using the PHQ2. If a patient screens positive then they are screened using the PHQ9. If a patient screens positive using the PHQ2 but negative using the PHQ9 they are being reported as screening positive for depression with no follow up plan.

Twenty two social workers engaged in the NCC Webinar Treating Depression in Dialysis Patients. Facilities have access to Network 3 Behavioral Health “Mindful Pathways” webpage with resources and general behavioral health clinical screening and treatment interventions https://www.qirn3.org/Ongoing-Projects/Behavioral-Health.aspx.

Figure 28 – Percent of Patients Who Screened Positive for Depression and are Receiving Treatment



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2023

Nursing Home (Blood Transfusion, Catheter Infection, and Peritonitis) May 2022-April 2023

Goal of QIA: Achieve 6% decrease in the hemodialysis catheter infection rate, among 10% of the nursing home residents receiving dialysis in-center, from the baseline to the end of the May 2022- April 2023 performance period. Achieve a 3% decrease in the rate of blood transfusions, among 10% of the nursing home dialysis patients receiving dialysis in-center, from the baseline to the end of the May 2022- April 2023 performance period.

Results: As shown in the figures above, providers in the Network 3 service area did not meet these goals. Although we oversampled the number of facilities to include in this measure, the baseline data for all included was very small and difficult to impact. There were no nursing home residents receiving routine peritoneal dialysis during this performance period. As a result, the peritonitis figure lacks remeasure outcomes.

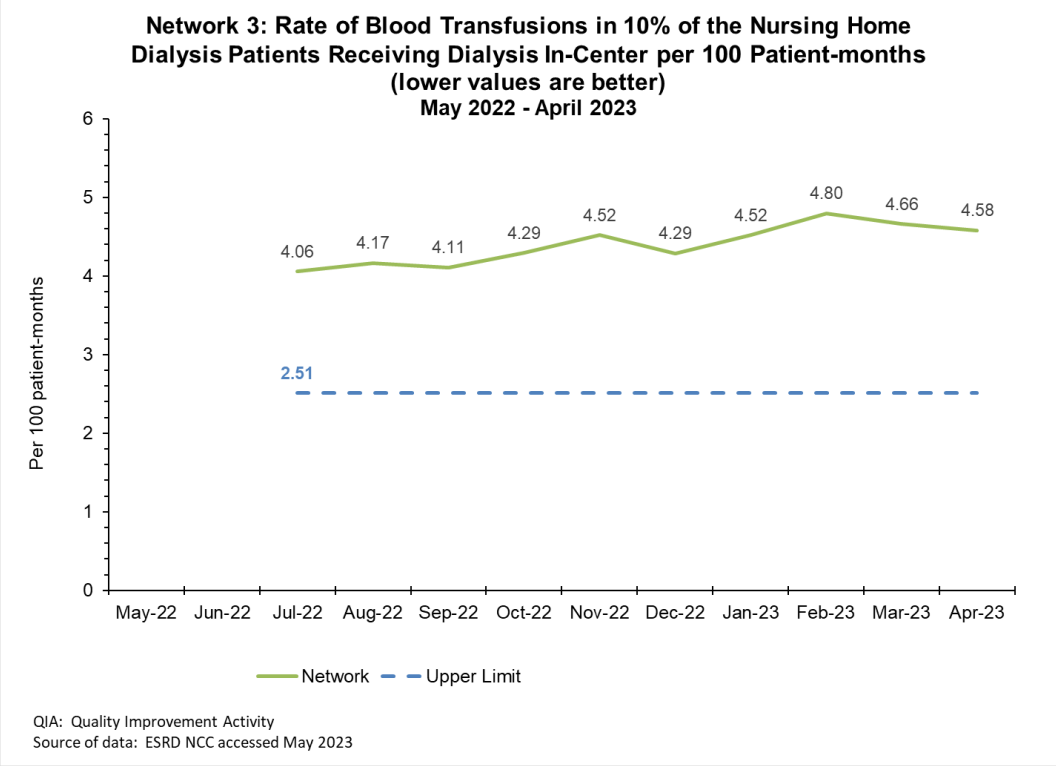
Interventions: We engaged a multidisciplinary advisory committee to gather barriers and recommended best practices for reducing catheter related infections and decreasing blood transfusions in nursing home residents receiving dialysis in center.

Facilities were encouraged to engage the interdisciplinary team and work together to develop action plans to address the barriers to increasing home dialysis. We encouraged use the Institute for Healthcare (IHI) Model for Improvement methodology, 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 implement and evaluate test of change. We engaged facilities for technical assistance through one on one calls, group calls, virtual and or in person visits during which we provided coaching and guided them to resources. To support increased knowledge of nursing home staff on the care of kidney patients, we shared educational modules titled, *Dialysis Access Care in Skilled Nursing Facilities, Nutrition for Dialysis Residents in Skilled Nursing Facilities, The Basics of Kidney Disease and Dialysis.*

Identified Best Practices: We engaged three dialysis facilities connected to a nursing home. These facilities engaged nursing home staff in meetings to improve communication and information sharing. As a result, the nursing home Director of Nursing (DON) began attending the dialysis quality meetings, the educational modules referenced above were shared with the DON to promote to the nursing home staff, and dialysis staff would begin participating in nursing home staff education events to provide education on dialysis patient related topics, such as, vascular access care, and medications.

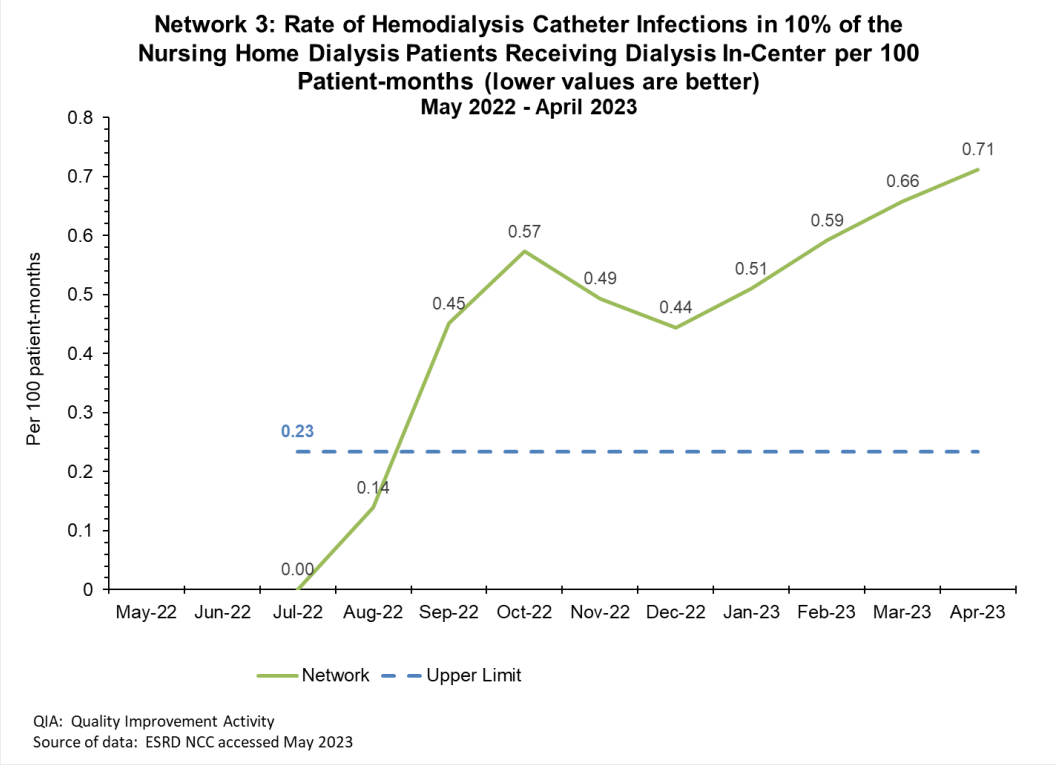
Barriers: These measures were designed to address anemia management and infection control opportunities identified in providers of dialysis care in the nursing home setting. The alternative measure we participated in was developed for networks where routine dialysis services in the nursing home setting were not available. Although we oversampled the number of facilities to include in this measure, the baseline data for all included was very small and difficult to impact. Facility results of RCAs found most often that these patients had very complex medical conditions and many were at the end of life.

Figure 29 – Rate of Blood Transfusions Among Selected Nursing Home Residents



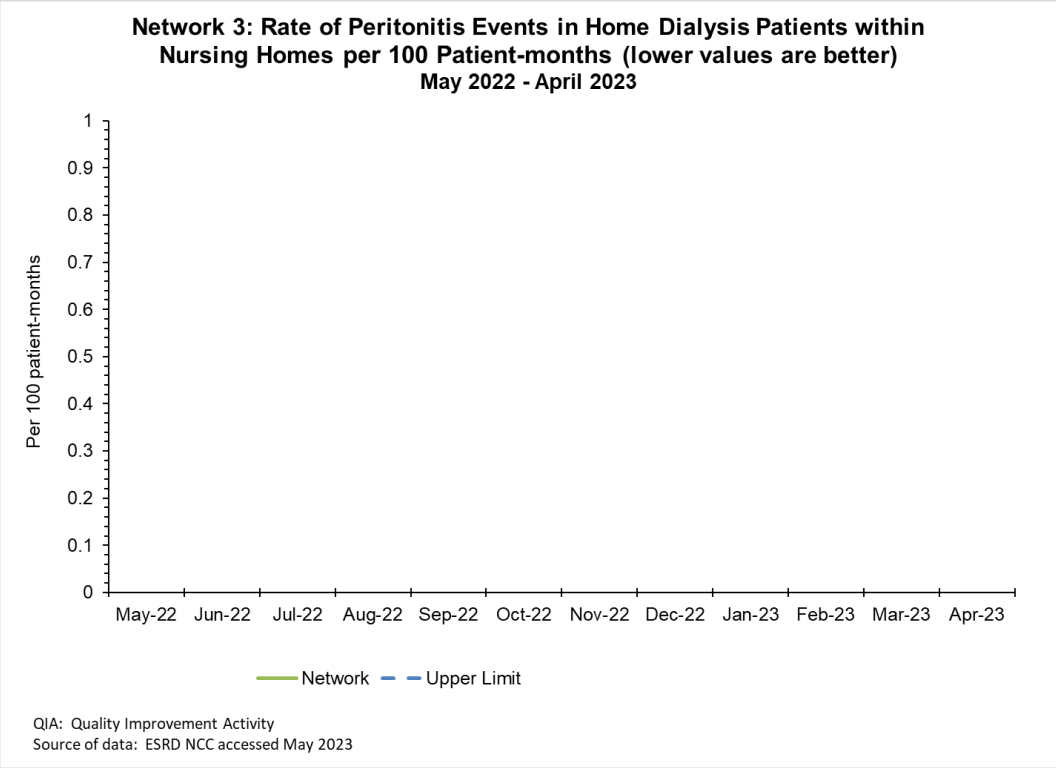
QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2023

Figure 30 – Rate of Catheter Infections Among Selected Nursing Home Residents



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2023

Figure 31 – Rate of Peritonitis (zero) Among Selected Nursing Home Residents

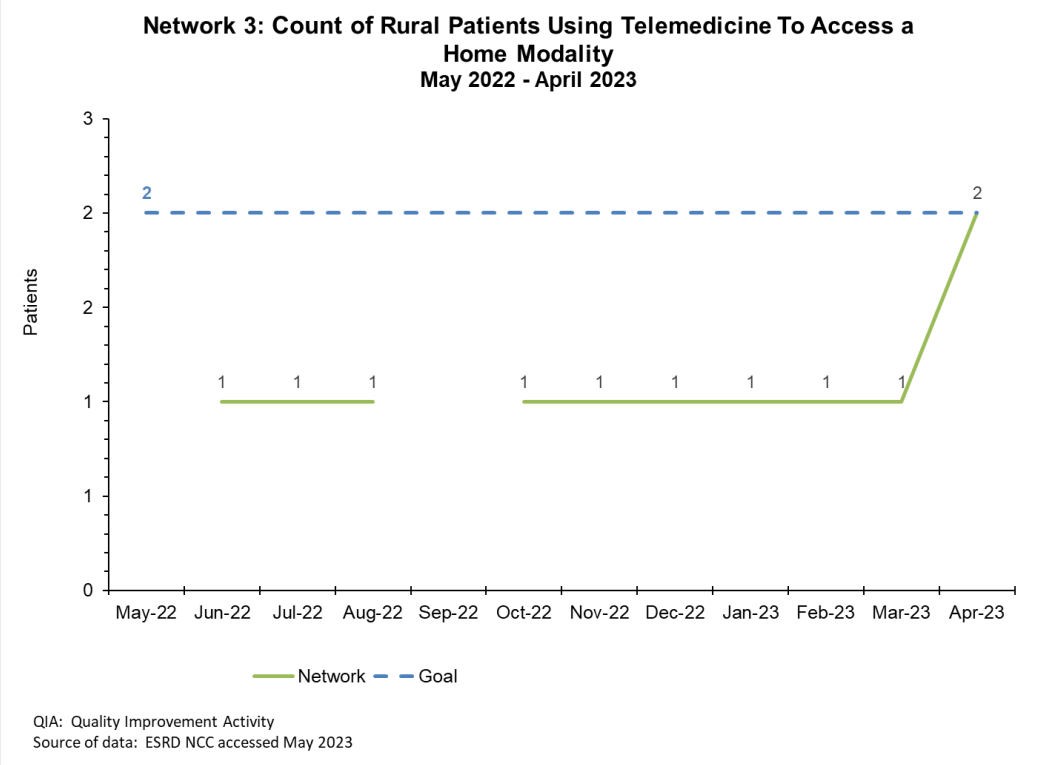


Telemedicine May 2022-April 2023

Goal of QIA: Achieve a 2% increase in the number of rural ESRD patients using telemedicine to access a home modality from the baseline to the end of the May 2022- April 2023 performance period.

Results: As shown in the figure above, the goal expected was achieved. However, there were only three patients eligible for this measure. Two of the three received care for home dialysis via telemedicine.

Figure 32 – Number of Rural ESRD Patients on a Home Modality Using Telemedicine



Pneumococcal Vaccinations (PCV13 & PPSV23) May 2022-April 2023

Goals of the QIA:

- Achieve a 20% increase in the number of patients receiving PCV13 from the baseline
- Ensure that 90% of dialysis patients receive PPSV23
- Achieve a 20% increase in the number of patients receiving a booster PPSV23 from the baseline
- Ensure that 85% of dialysis patients over 65 years old receive PPSV23
  All of these measures were based on EQRS data.

Results: According to figures seen above, the Network did not meet any of the goals under the pneumococcal vaccination QIA.

Intervention: We held a multidisciplinary Vaccinations Advisory committee meeting to address identified barriers and recommend effective strategies for pneumococcal vaccinations. As with other vaccination QIAs, to enhance quality improvement efforts, we implemented a data-driven approach through the launch of the Quality Insights ESRD Facility QIA Dashboard and ESRD Facility Report. These tools provided facilities with performance metrics and valuable insights for identifying areas of improvement. We promoted the implementation of the Institute for Healthcare Improvement (IHI) Model for Improvement methodology, which includes the utilization of root cause analysis (RCA), the development of facility-specific quality improvement plans, and the implementation of Plan-Do-Study-Act (PDSA) cycles to assess and evaluate changes.

Furthermore, we strongly recommended the application of the ESRD NCC Vaccinations Change Package, a comprehensive resource offering guidelines and tools to increase vaccination uptake. We also promoted effective conversation strategies to engage patients in discussions about vaccinations, considering their individual perspectives and concerns.

In early 2022, the new ACIP recommendations on the use of 15-Valent Pneumococcal Conjugate Vaccine (PCV-15) and 20-Valent Pneumococcal Conjugate Vaccine (PCV-20) was released. To assist facilities in administering the new pneumococcal vaccine, recommend vaccines effectively, boost vaccine confidence, and secure trust in vaccination conversations, we shared resources from the CDC, Immunization Coalition and the American College of Physicians.

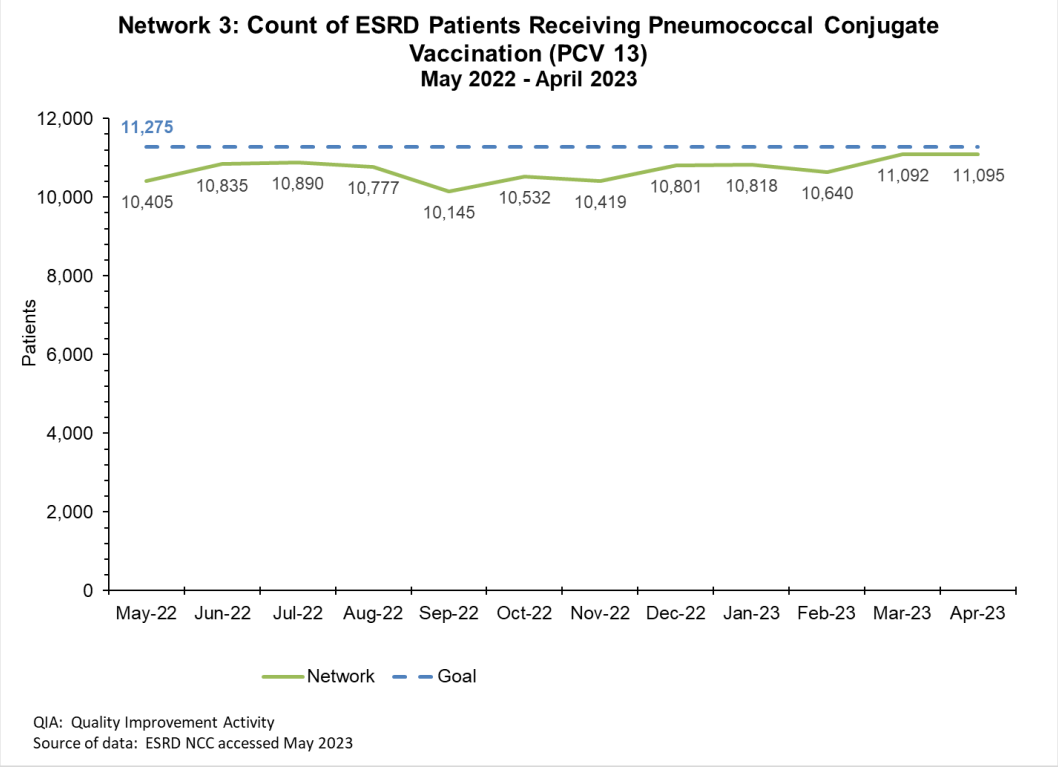
In 2022 also, as the pneumococcal vaccination shifted from the clinical module to the patient module in EQRS, we offered technical support to facilities to help them navigate this transition.

We supported facilities through in-person or virtual meetings, one-on-one support, sharing of best practices and dissemination of solutions to highly reported barriers through the QIA Bulletin

Identified Best Practices: Interdisciplinary team approach, organized planning, systematic monitoring and tracking were the identified best practices in vaccinations.

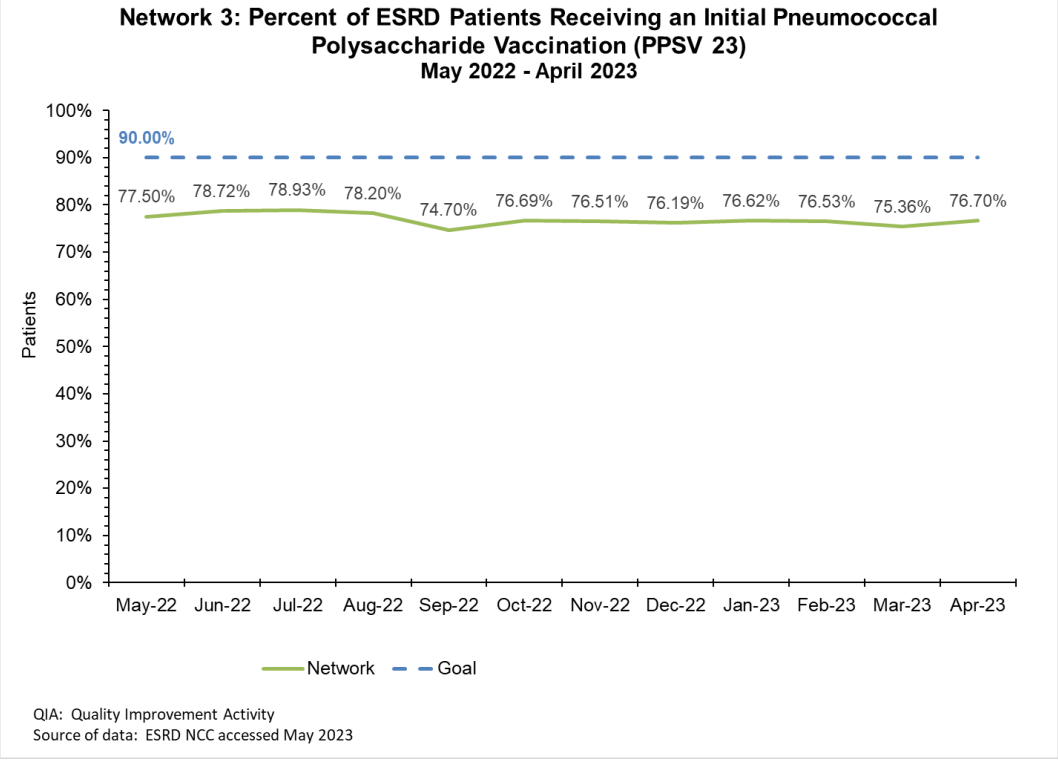
Barriers: With the release of the ACIP recommendations, facilities began transitioning their pneumococcal protocols. However, the impact of this transition was not captured in the data. Facility staff turnover, competing priorities and lack of back up EQRS user were identified facility barriers. Finally, there were patients who received vaccinations outside the facility but were unable to provide documentation or proof of their immunizations.

Figure 33 – ESRD Patients Receiving Pneumococcal Conjugate Vaccination (PCV-13), cumulative



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2023

Figure 34 – ESRD Patients Receiving an Initial Pneumococcal Polysaccharide Vaccination (PPSV 23)



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2023

Figure 35 – ESRD Patients Receiving a Booster Pneumococcal Polysaccharide Vaccination (PPSV 23)

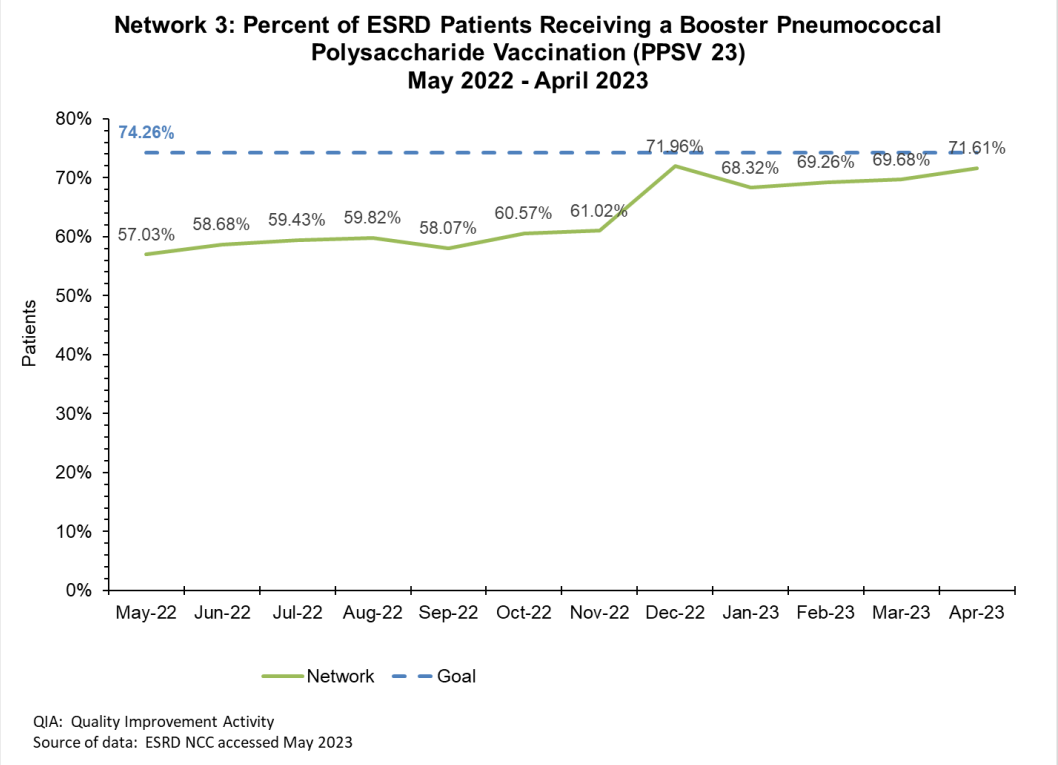
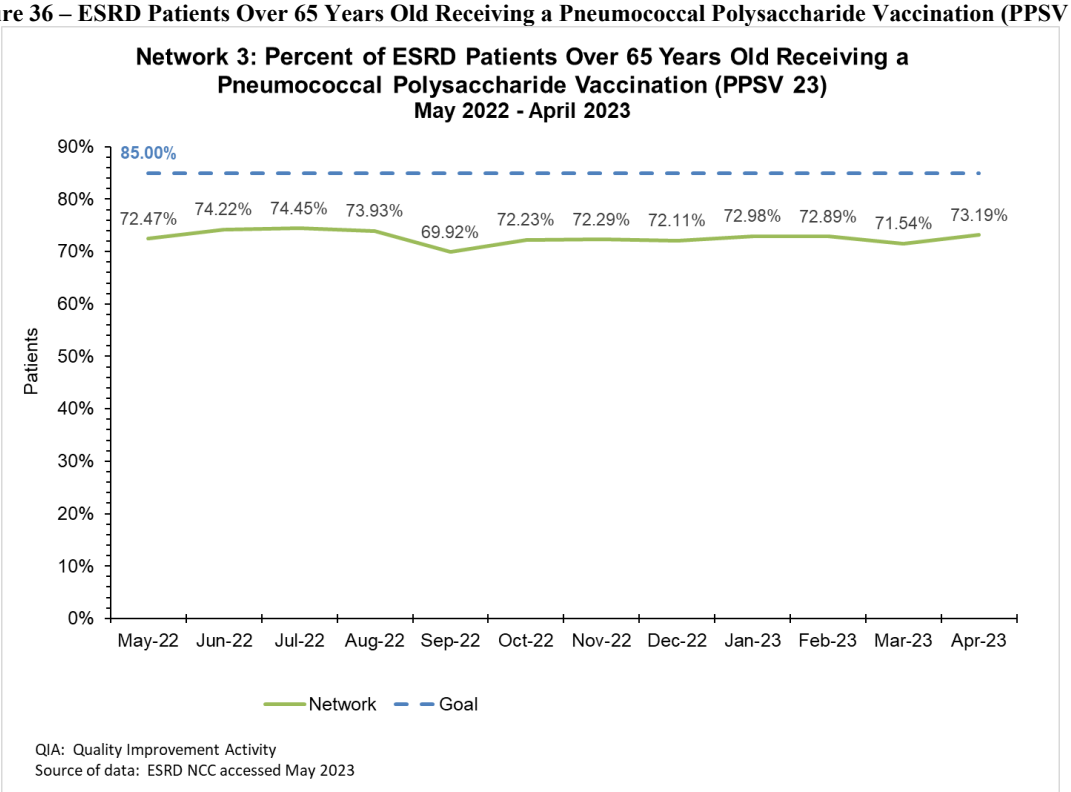
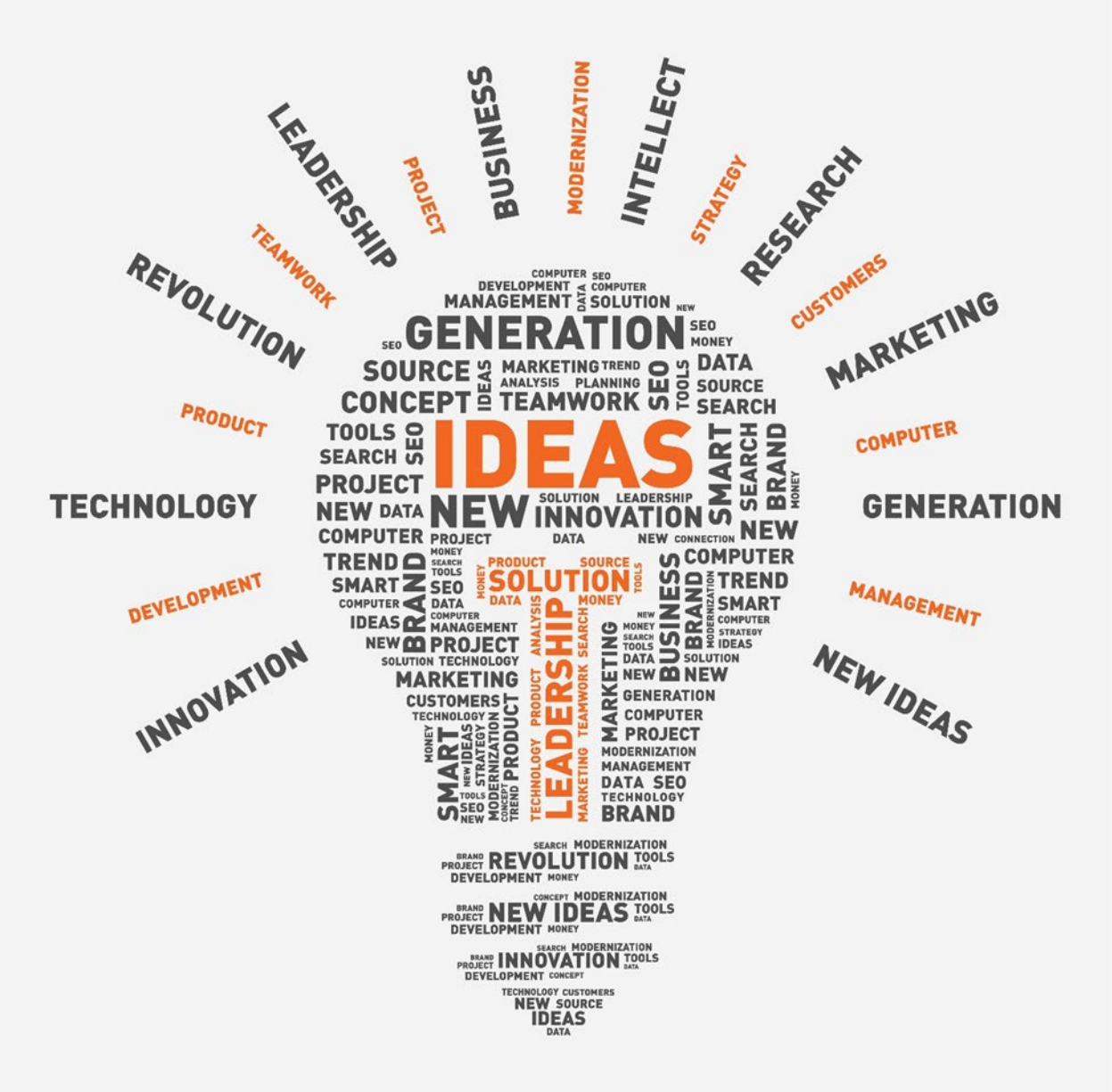


Figure 36 – ESRD Patients Over 65 Years Old Receiving a Pneumococcal Polysaccharide Vaccination (PPSV 23)




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

ESRD Network Recommendations

Facilities that Consistently Failed to Cooperate with Network Goals

Due to staffing shortages causing facility management to frequently need to provide direct patient care and other stressors caused by the COVID-19 pandemic, we once again found it difficult to engage with facility staff in 2022-2023 and convince them that some of our initiatives were worth paying attention to. However, all facilities in the Network 3 geographic area eventually cooperated with Network goals and participated in our quality improvement interventions when requested.

Recommendations for Sanctions

We did not recommend sanctions for any facilities in 2022. There are a few dialysis facilities that would have certainly qualified for sanctions, but the resultant access to care issues that patients could have experienced ultimately caused us to choose not to pursue this course of action.

Recommendations to CMS for Additional Services or Facilities

We did not recommend any additional services or facilities in 2022. The facilities and services available to patients in the Network 3 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
team
emergency room
medical
service
help
urgent
danger
disaster
supplies
protection
safe
jeopardy
resilience
kit
evacuation
stretcher
paramedic
business
alarm
medic
equipment
disease
emergency
incident
urgency
threat
natural disaster
information
property
natural
crisis
doctor
government
recovery
nurse
health
environmental
situation
risk management
public
response
rescue
hospital
security
room
intervention
operations
medicine
life
accident
risk
education
loss
system

ESRD Network COVID-19 Emergency Preparedness Intervention

Within 2022-2023 our response efforts remained focused on increasing awareness, education and promotion of the COVID-19 vaccines and mandates. As providers and patients' needs and questions evolved regarding the COVID-19's variants, vaccines, required boosters, masking mandates, and updated guidance we implemented an effective and timely plan to disseminate tools and resources. In addition to emails, monthly newsletter and social media communications, our staff was prompt in relaying the latest updates as well as time sensitive materials and information to dialysis providers and patients.

We continued utilizing KCER's National Emergency Situational Status Report (ESSR) and the CDC's NHSN data to conduct analysis of new COVID-19 cases, identify hotspots throughout our Network service areas, and validate vaccination rates. Using this information, our team provided targeted one to one technical assistance to dialysis centers. Via this technical assistance, we were able to address emerging issues, identify access to COVID-19 and Flu vaccines for staff and patients, identify if providers were applying interventions equivalent to or more stringent than the CDC's recommendations, addressed barriers as well as successes, and provide individualized support to improve overall vaccination rates.

Highlights from COVID-19 Pandemic Timeline (May 2022 – April 2023)

Mid 2022

May 28, 2022 - The weekly average of new COVID-19 infections in the U.S. is now six times higher than it was in 2021. Currently, there are 119,725 new cases reported each week– a number that is "grossly underreported" according to experts– compared to May 28, 2021, when there were 17,887.

June 30, 2022 - As COVID-19 case numbers rise across the U.S. due to the highly transmissible omicron subvariants BA.4 and BA.5., FDA calls for Omicron-specific updates to COVID-19 vaccine boosters from Pfizer-BioNTech and Moderna in fall 2022.

Late 2022

September 19, 2022 - President Joe Biden declared that the COVID-19 pandemic is over in the U.S. He added that "we still have a problem with COVID. We're still doing a lot of work on it"

November 4, 2022 - Pfizer and BioNTech say the new COVID booster generates higher protection against the omicron variants. CDC warns of tough winter as flu, RSV, and COVID collide.

November 22, 2023 - NIH launches the MakeMyTestCount.org website, developed through NIH's Rapid Acceleration of Diagnostics Tech program, which allows users to anonymously report the results of any brand of at-home COVID-19 test.

Early 2023

January 30, 2023 - The Biden Administration announces that it plans to end the COVID-19 national and public health emergencies on May 11, 2023.

April 10, 2023 - President Joseph Biden signs a bipartisan congressional resolution to end the COVID-19 national emergency, bringing it to a close after three years and weeks before it was set to expire alongside a separate public health emergency.

April 18, 2023 - The FDA releases updated guidance to simplify the use of COVID-19 vaccines: Adults who have not yet been vaccinated will get one dose of an updated bivalent shot; seniors and immunocompromised individuals may get another booster of the bivalent vaccine at least four months following their first dose of the bivalent vaccine; children 6 months through 5 years of age may receive a bivalent vaccine, but the number of doses that they receive will depend on the vaccine and their vaccination history.

ESRD Network Significant Emergency Preparedness Intervention

Maintaining sustainable partnerships with community stakeholders was essential to our ongoing emergency preparedness and response efforts. Therefore, we continued engagement with the NJ Group for Access and Integration Needs in Emergencies and Disasters (NJ GAINED), which addressed COVID-19 conditions, actions, needs (current and anticipated) and status reports from state and county level agencies. We have also continued to host situational status calls with the Puerto Rico Emergency Preparedness and Response Activities Renal Coalition (PREPARAR-C) and participate in meetings with the US Virgin Islands ESF-8 COVID-19 workgroup. 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.

Additionally, we understand how natural and/or human caused emergencies such as winter storms, hurricanes, severe weather, civil unrest, etc. may influence patients, staff and dialysis facility operations. As a result, we maintained close communication with dialysis providers before and after each event to ensure continuity of facility operations and care of all patients. Providers in our regions are very diligent in reporting and communicating operational status and needs.

Timeline of Weather/Natural Events Impacting the Network 3 Service Area (May 2022 – April 2023)

May 2022

We informed all Network 3 dialysis providers of the Monkeypox Virus Infection in the United States and Other Non-endemic Countries.

July 2022

We were informed of possible issues impacting the US Virgin Islands Water and Power Authority in St Croix and disruption to the water supply due to a desalinization plant being shut down. This was related to a significant amount of sargassum/algae in the region. We were prompt in establishing contact with both dialysis providers in Saint Croix to assess impact to their operations (no impact). Additionally, we email the Director of Public Health Preparedness at Department of Health Govt. of the Virgin Islands and the Director of the Virgin Islands Territorial Emergency Management Agency (VITEMA) to establish lines of communication and facilitate any support to the dialysis patients and providers in St Croix. Federal partners were activated (FEMA, HHS) to work with the Water and Power Authority and government of US VI. The water plant never shut down.

September 2022

Hurricane Fiona was a Category 1 hurricane, with maximum sustained winds of 85 mph, when it made landfall in Puerto Rico on 9/18/23. Hurricane Fiona struck Puerto Rico's southwest coast bringing flooding, mudslides and an island-wide power blackout. By the morning of 9/19/23, a small number of the more than 1.4 million power customers in Puerto Rico began to have electricity restored. More than 778,000 residents in Puerto Rico were without drinking water. The Puerto Rico Emergency and Response Activities Renal Coalition (PREPARAR-C) was activated since the week before the storm. With the assistance for local and federal partners all needs/requests, duplicity of efforts and communications were handled in a timely manner. Dialysis providers were able to sustain operations and patients received treatments.

December 2022

Winter Weather Event – A minor winter storm impacted the state of NJ in the month of December. As precaution, providers activated their contingency plans for the safety of their patients and staff. Each provider's plan differed depending on the amount of snow predicted for their area. Overall the majority opted to close with a handful implementing delayed openings. Plans for continuity of patient

care in those who closed included resuming operations a day after the storm's impact with a group of providers who opted to provide adjusted treatments. All decisions for adjustment to patient treatments and activation of contingency plans involved the facility's governing body, interdisciplinary team and/or Medical Director. We maintained close contact with providers to assess needs and impact. Post event, we did not receive notification of any permanent impact to facility operations or to the continuity of patient care.

February 2023

On Monday 2/27/23 a construction crew working on an unrelated project mistakenly struck a water main, a 16-inch pipe on Observer Highway and Madison Street in Hoboken. We sent a situational awareness message to providers in the area. A State of Emergency had been declared, forcing schools and businesses to close. The City of Hoboken and Mayor Bhalla released a statement saying repairs and water disruption would continue into Wednesday. Only one facility reported been affected by this incident and by the said date (3/1/23) the water supply had been restored, at which point the facility resumed patient treatments.

March 2023

On Monday 3/27/23 we sent a situational awareness message to NJ dialysis providers in the Burlington, Camden and Gloucester counties regarding monitoring in the water quality of the Delaware River following a chemical spill on Saturday near Bristol, Pennsylvania. More than 8,000 gallons of latex finishing material, a water soluble acrylic polymer solution, spilled into Otter Creek with a maximum potential release of 12,000 gallons, according to a statement from the U.S. Coast Guard. New Jersey American Water was assessing impact and maintained close contact with us. Ultimately, there were no contaminants found in New Jersey's water system.

Acronym List Appendix

This appendix contains an acronym list 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.