ESRD NETWORK 2019 ANNUAL REPORT

ESRD Network 10

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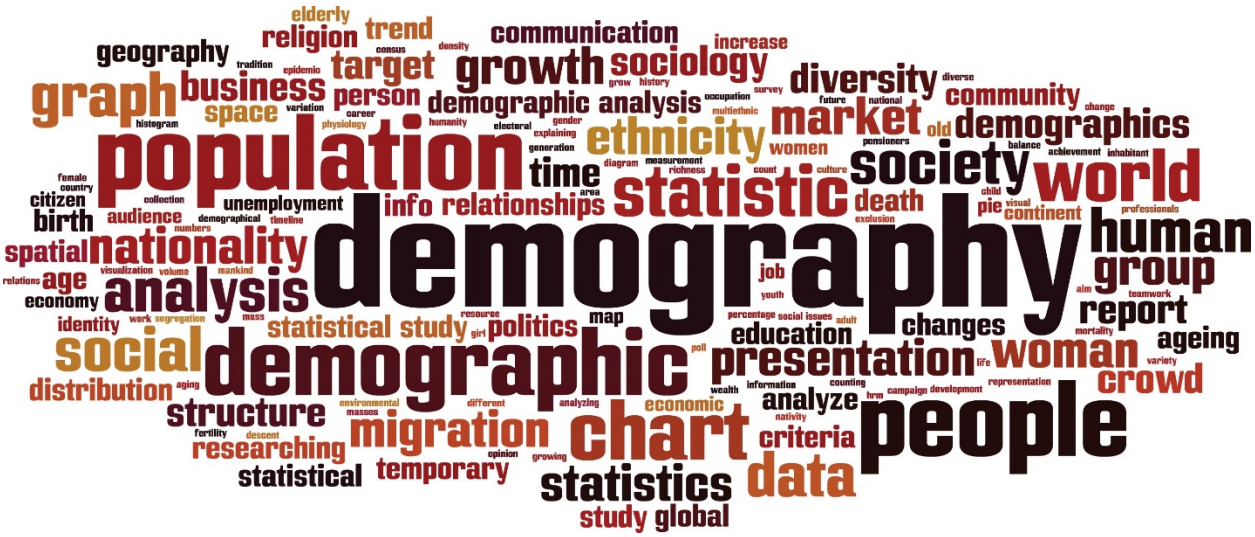
ESRD DEMOGRAPIC DATA



During 2019, Qsource ESRD Network 10 collaborated with its many stakeholders to improve the quality of care for 31,036 dialysis and transplant patients, receiving treatment in 352 providers of dialysis therapy and nine transplant centers in the State of Illinois. Qsource ESRD Network 10 is a member of the ESRD Networks Strategies Division of Qsource, a nonprofit, healthcare quality improvement and information technology consultancy headquartered in Memphis, Tennessee.

The total population of Illinois, the single-state area of Network 10, is 12,830,632. Springfield is the capital city of the state. The top six cities by population are:

- Chicago (2,695,598)
- Aurora (197, 899)
- Rockford (152,871)
- Joliet (147,433)
- Naperville (141,853)
- Springfield (116,250)

About one-half of the population of Illinois lives in the metropolitan Chicago area. In total, 83 percent of the population lives in urban areas and 17 percent of the population lives in rural areas. Population characteristics are illustrated in the table below.

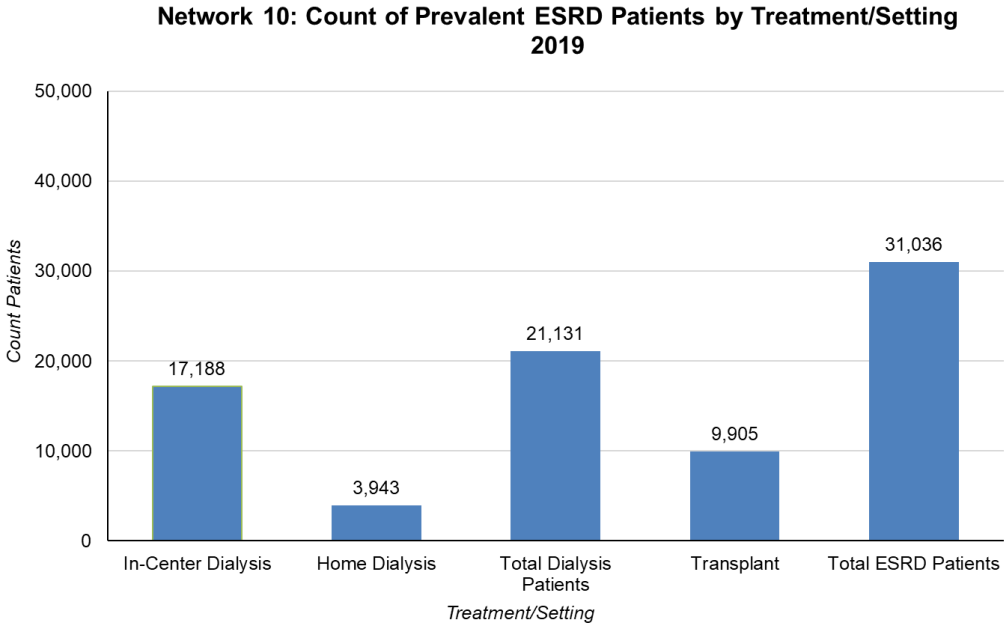
Figure 1 – 2010 Census General Population – Illinois
Race, Age, Ethnicity & Gender Information*

State	Illinois
Population	12,830,632
State Rank	5th
White	72%
Black	15%
Asian	5%
Other	8%
Hispanic (All Races)	15.8%
Under 19	24%
19 – 64	62%
65 & Over	14%
Male	49%
Female	51%

*U.S. Census Bureau
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

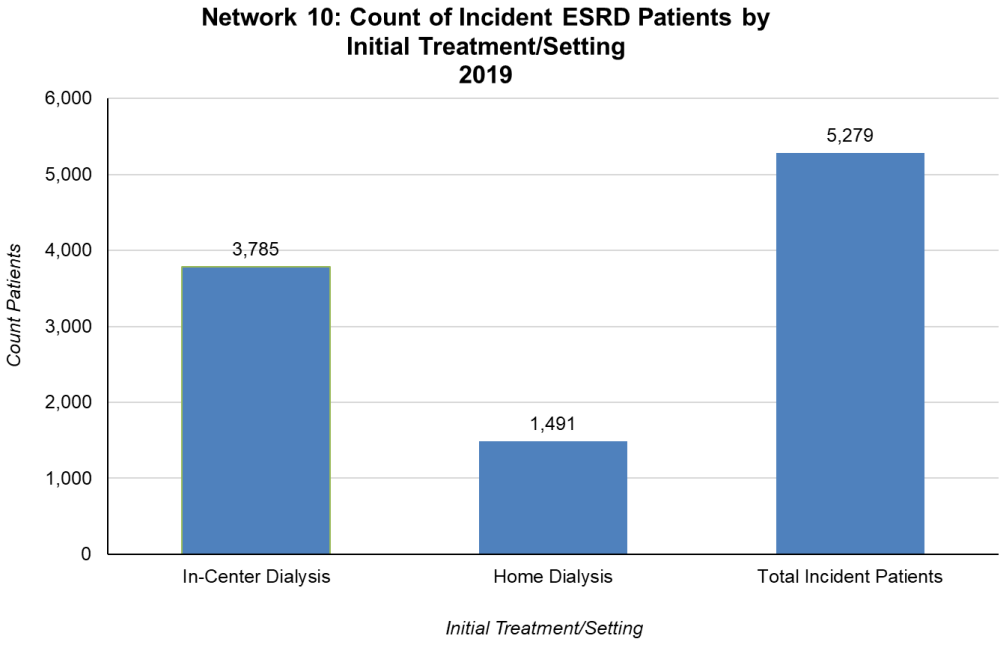
At year-end 2019, ESRD Network 10 was comprised of 352 total ESRD facilities (Graph 3), serving 31,036 dialysis patients (Graph 1). Additionally, Illinois had nine transplant centers (Graph 3) and a total of 9,905 transplant patients (Graph 1).

Graph 1-NW Count of Prevalent ESRD Patients by Treatment/Setting



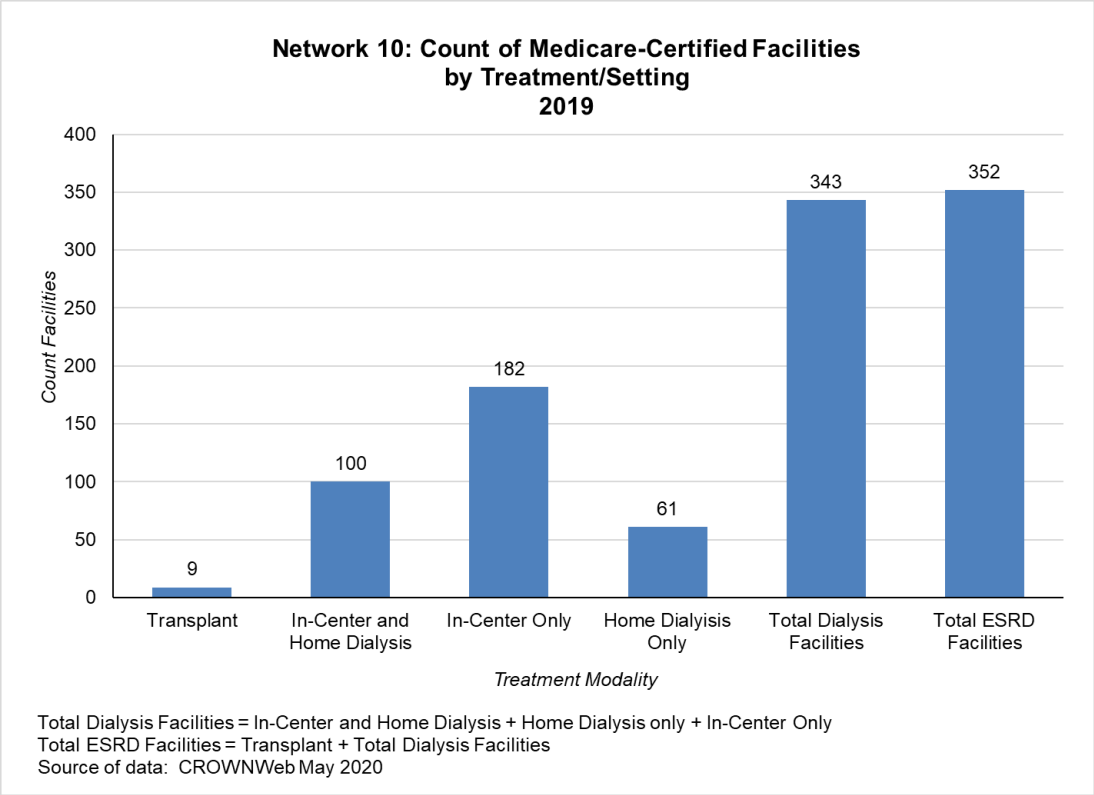
Total Dialysis Patients = In-Center Dialysis + Home Dialysis
Total ESRD Patients = Transplant + Total Dialysis
SNF dialysis patients are not shown due to small numbers.
Source of data: CROWNWeb May 2020

Graph 2-NW Count of Incident ESRD Patients by Treatment/Setting



Total Incident Patients = In-Center + Home + Kidney Transplant
Kidney Transplant patients are not shown due to small numbers.
Source of data: CROWNWeb May 2020

Graph 3-NW count of Medicare-certified facilities by treatment/setting



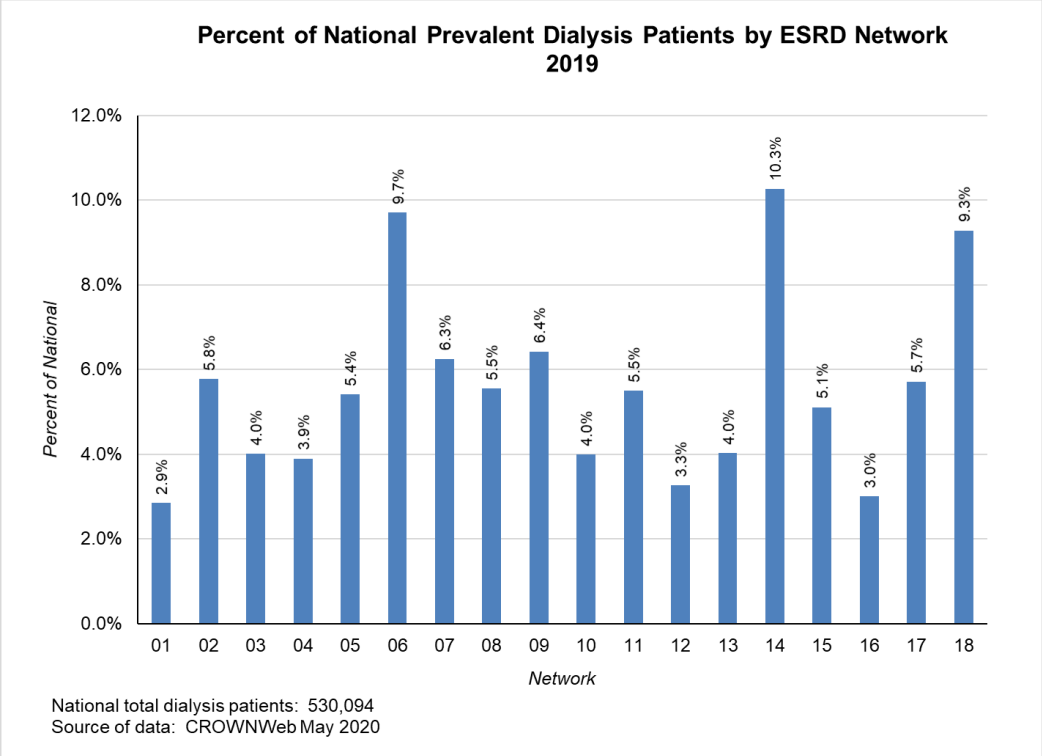
Source of data: CROWNWeb

On the following pages, graphs 4, 5, and 6 show national prevalent and incident patients by ESRD Network and percent of Medicare-certified dialysis facilities by ESRD Network.

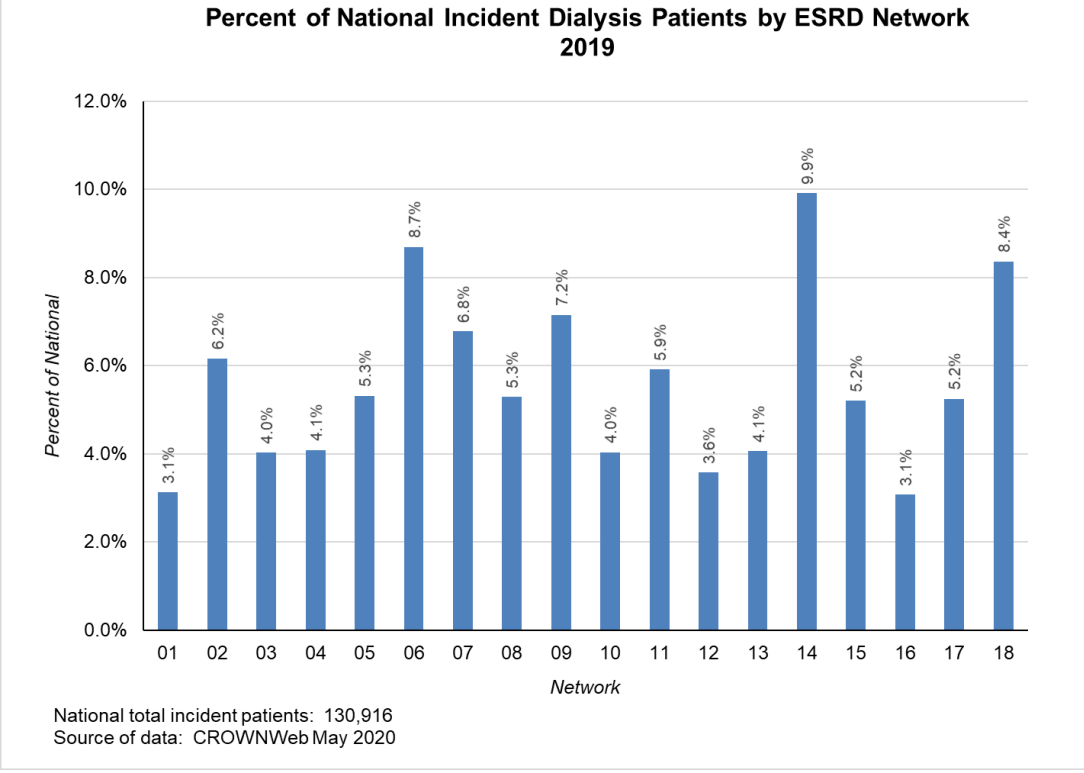
Following that, graph 7 illustrates percent of national home hemodialysis and peritoneal dialysis patients by ESRD Network.

Finally, graphs 8 and 9 show national comparisons for transplant recipients and transplant centers.

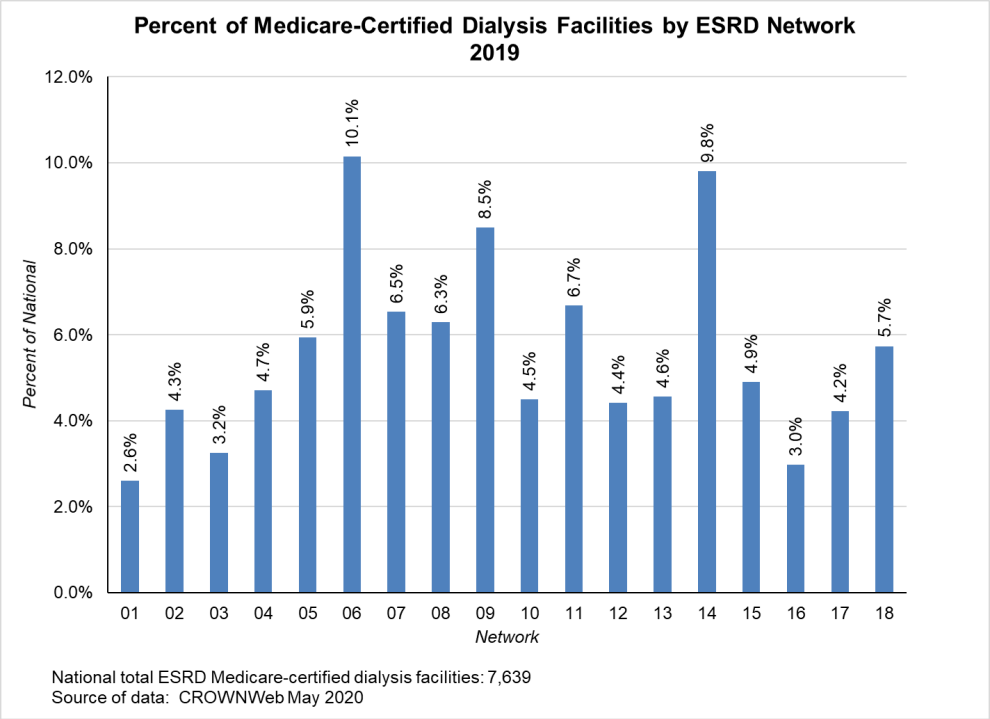
Graph 4-Percent of National Prevalent Diaysis Patients by ESRD Network



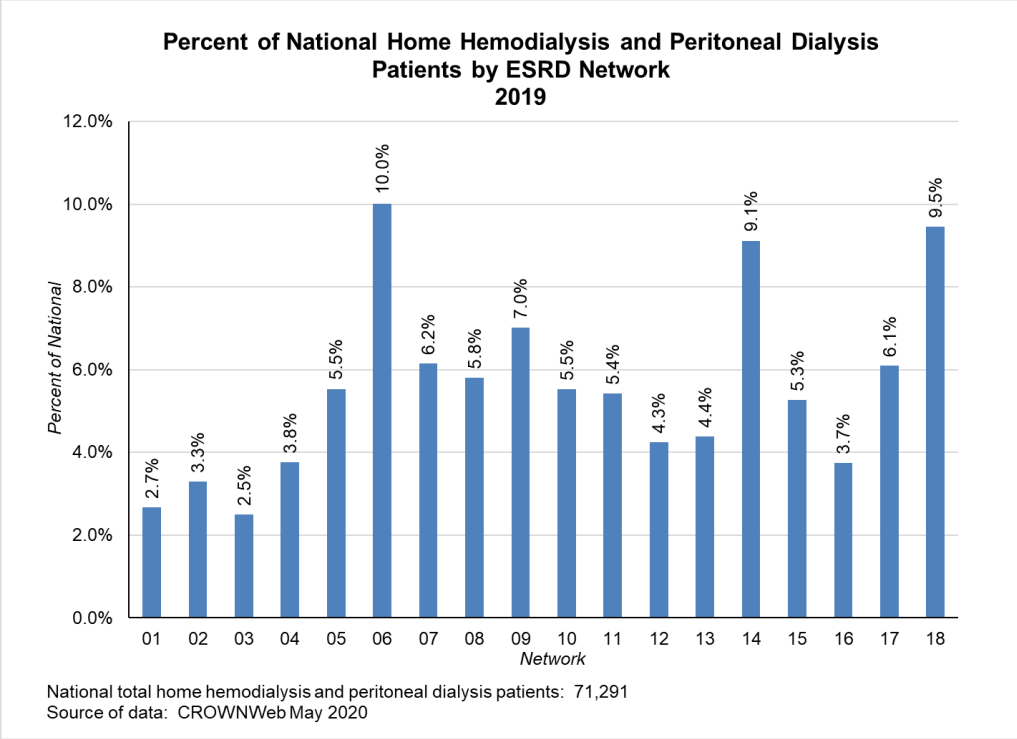
Graph 5- Percent of National Incident Diaysis Patients by ESRD Network



Graph 6- Percent of Medicare-certified Dialysis Facilities by ESRD Network

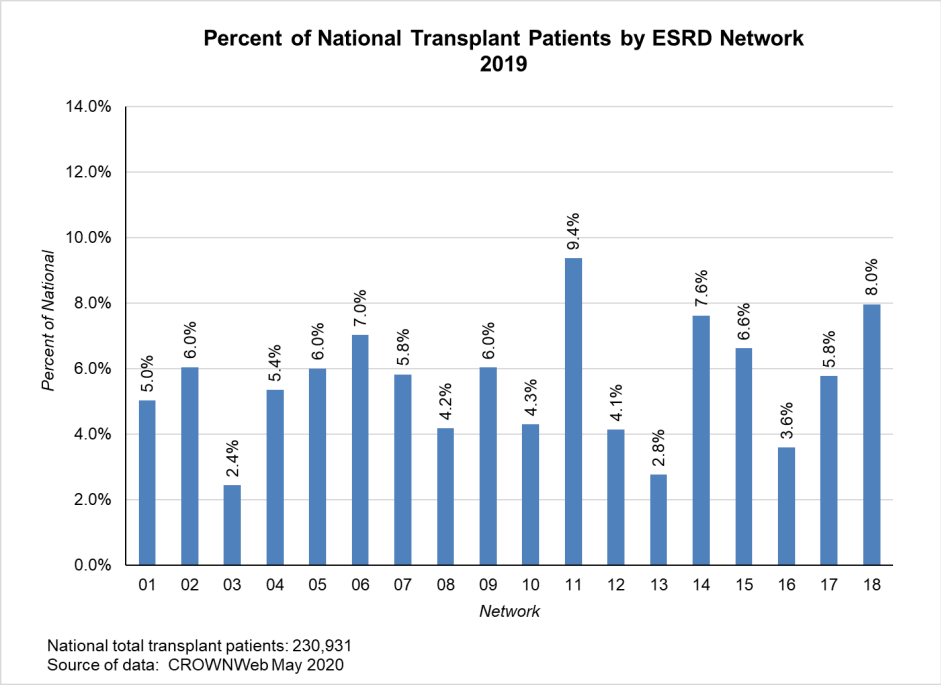


Graph 7-Percent of National Home Hemodialysis and peritoneal dialysis patients by ESRD Network



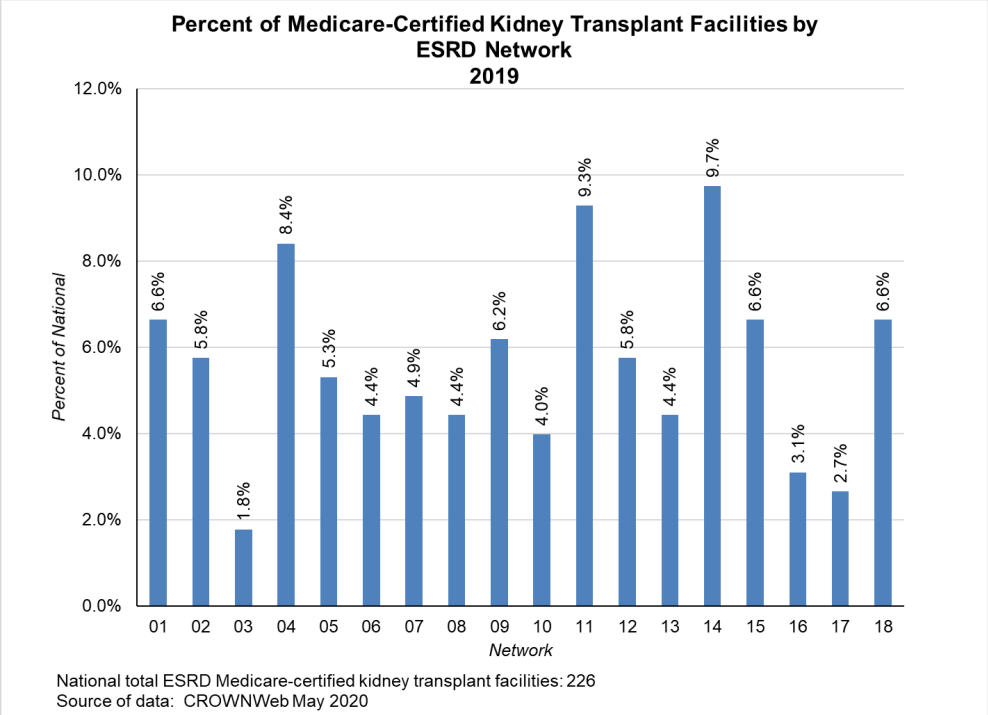
Source of data: CROWNWeb

Graph 8-Percent of national transplant patients by ESRD Network



Source of data: CROWNWeb

Graph 9-Percent of Medicare-Certified Kidney transplant facilities by ESRD Network



Source of data: CROWNWeb

ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA

ESRD Network 10 responds to calls for assistance from stakeholders, including dialysis patients, caregivers, family members, dialysis clinic staff members, and physicians. During 2019, the majority of contacts were received in the following CMS-defined categories:

Facility Concern (44%): Facility concerns are brought to the Network's attention by staff members or physicians of Network 10 dialysis clinics. Facility concerns are often made in an effort to ask for assistance with an issue before it grows to be larger concern. Facility staff members frequently call to discuss situations involving patients with behavioral issues and seek guidance to diffuse tense situations within the dialysis setting.

Access to Care (19%): These contacts deal specifically with concerns for patients who are in danger of being involuntarily discharged (IVD) from their dialysis clinics and also in regard to patients who have been involuntarily discharged without a placement at another unit. In many instances, ESRD Network 10 works with individual facilities to identify and address difficulties in placing or maintaining patients in treatment. These access to care cases may come to the Network's attention in the form of a grievance, or they may be initiated by facility staff. An IVD is a discharge initiated by the treating dialysis facility without the patient's agreement. An involuntary transfer (IVT) occurs when the transferring facility temporarily or permanently closes due to a merger, or due to an emergency or disaster situation, or due to other circumstances, and the patient is dissatisfied with the transfer to another facility. A failure to place is defined as a situation in which no outpatient dialysis facility can be located that will accept an ESRD patient for routine dialysis treatment.

Immediate Advocacy (7%): Patients often reach out to the Network for assistance in solving issues they are experiencing in their dialysis clinics. In the case of Immediate Advocacy, the concerns are ones that can be settled within seven calendar days and do not involve clinical issues. For issues which take more time, the case will be escalated to a general grievance to allow more time for investigation. The case may be escalated to a clinical quality of care grievance if clinical issues are identified during the course of the initiation investigation.

General Grievance (13%): These are cases of a more complex nature that do not involve clinical quality of care issues, and that need more than seven calendar days for resolution. General grievances often involve communications problems between staff and patients, disagreements over treatment times/assignments, and the patient perception of lack of professionalism by dialysis facility staff members.

Clinical Quality of Care (2%): These are circumstances in which the grievant alleges that an ESRD service received from a Medicare-certified provider did not meet professionally recognized standards of clinical care. Clinical QoC cases may be either 1) a patient-specific Clinical QoC case, in which the care impacted a specific patient, or 2) a general Clinical QoC case, in which two or more patients at a facility were impacted. All Clinical QoC grievances include review by a Network Registered Nurse (RN) for the clinical aspects of the case.
The Network uses the trending information from grievances to find existing resources or develop new resources for patients and staff to assist in solving conflicts and in improving communications for all parties. A sample of resources provided is listed below:

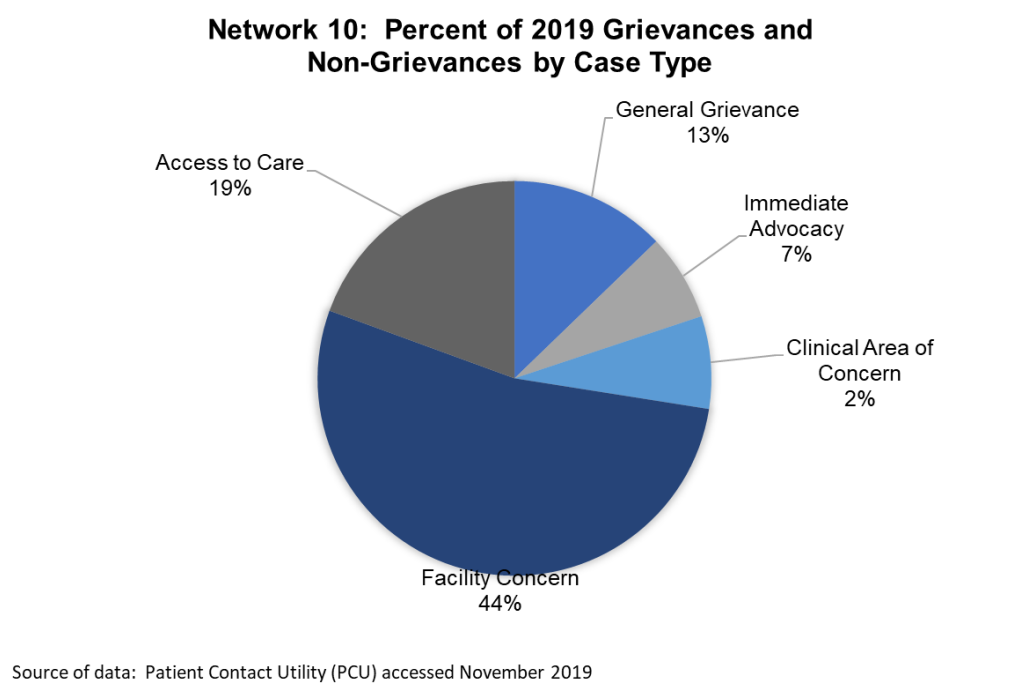
Network Interventions for Providers: referenced *Decreasing Dialysis Patient-Provider Conflict (DPC) Toolkit*; Network staff participated in care or grievance conferences; advocated for patient rights; education about *The ESRD Network Forum - Dialysis Patient Grievance Toolkit*; discussed staff

professionalism, mental health evaluation and follow up needs; highlighted websites for patient and caregiver education resources; discussion of behavioral agreement or agreements for change; identifying other treatment modalities; staff education about end-of-life, palliative care, and hospice services; review of plan of care (POC); informing clinic staff about related regulations and ESRD Conditions for Coverage (CfCs) guidelines; educating about involuntary discharge (IVD) or transfer (IVT) processes; and increasing awareness about Network-specific resources, such as *Kidney Patient Views - Real Life Stories from Real Patients* podcasts.

Network Interventions for Patients: educating patient on rights and responsibilities; initiating or participating in discussions about substance use/withdrawal, mental health evaluation and follow up, or other modalities; identifying providers for patients and caregivers; offered Network mediation; referred patient, family or caregiver to ESRD website and resources, such *The ESRD Network Forum - Dialysis Patient Grievance Toolkit;* assisting patient and representatives with self-advocacy by encouraging participation in care planning; discussing depression and coping skills; coaching on communication techniques; and identifying other agencies for possible referral(s) when appropriate.

At-Risk, IVD or IVT Interventions:
Provider specific: Network contacts clinic staff, physician or physician groups, as well as Medical Directors to discuss case issues and develop solutions; educating staff about coping strategies and anger management; recommending or assisting with implementation of a behavior contract or care plan agreement, coaching clinic staff about professionalism and communication techniques, advocating for patient rights and maintaining access to care by assisting with placement if/when and IVD or IVT event occurs. Patient specific: coaching patient/family/caregivers about communication technique and self-advocacy by routinely encouraging use of *The National Forum of ESRD Networks – The Dialysis Patient Grievance Toolkit;* educating patients about anger management, coping skills and/or mental health evaluation follow up, specifically, how lack of these skills or left untreated can lead to IVD or IVT events.

Graph 10



Source of data: Patient Contact Utility (PCU) accessed November 2019

ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA

Qsource ESRD Network 10 completed the quality improvement activities (QIA) as outlined in the 2019 CMS Scope of Work. Although the topics of the QIAs varied, each of the project plans employed the basic elements of quality improvement:

- Conducting an environmental scan/needs assessment with participating dialysis clinics
- Training dialysis clinic staff to use quality improvement tools of root cause analysis (RCA) and plan-do-study-act cycles (PDSA)
- Provision of resources to dialysis clinics based on needs identified by the QIA participants, with the goal for the Network to achieve customer focus.
- Overall focus on Shared Decision Making, Relationship Centered Care, and Motivational Interviewing to help patients and staff understand the importance of patient involvement in their care and modality choice
- Patient engagement through encouragement of facilities recruiting a patient or patients to help teach other patients about the QIA interventions
- Rapid Cycle Improvement through consistent reassessment of resources and interventions, based on the feedback from the participating dialysis clinics and patients
- Sustainable impacts through early introduction of the concept and re-enforcement of the importance of integration into the culture of the clinic

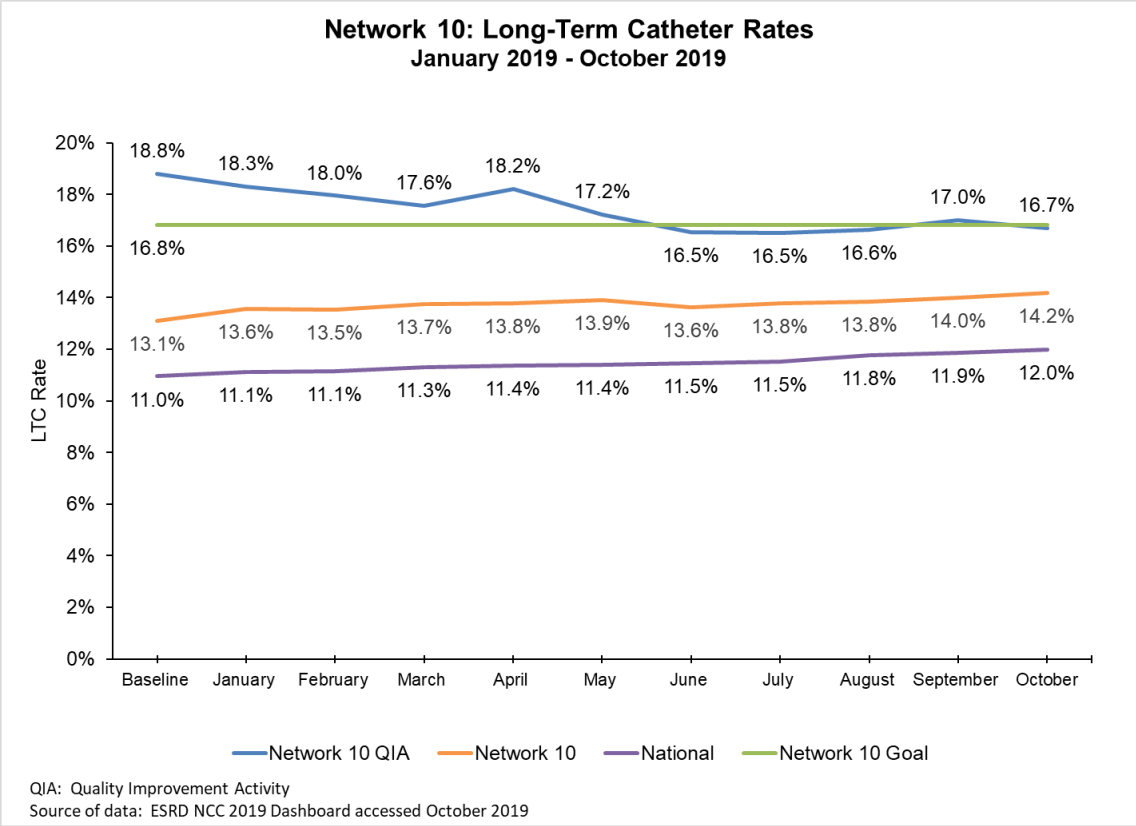
At the conclusion of each of the QIA, evaluations were given to the participating facilities to provide feedback to the Network on positives and negatives of the project. This feedback was used to develop the QIAs for the 2020 project cycle.

Details for each of the QIAs follow here.

Long Term Catheter Quality Improvement Activity

Within the project cohort of 28 dialysis clinics, rates of prevalent LTC dropped from 18.8% to 16.7%, exceeding the goal of reducing by 2%, as shown in Graph 11.

Graph 11



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

The project began with facilities completing an environmental scan to determine barriers to reducing prevalent LTC. Facilities were next trained in conducting RCA and PDSA methodologies to help them improve processes and to carry out changes which would be sustainable. Each dialysis clinic submitted individual PDSA plans. These were reviewed by Network staff and technical assistance was offered to the participating clinics throughout the project to help in goal attainment.

A Monthly Highlighted Resource was provided to each dialysis clinic with education and technical assistance for reducing LTC. Resources were found for dialysis clinic staff and also for direct patient use. The Network encouraged the facilities to choose a patient volunteer to help distributing the information and in collecting assessment data after the patients had a chance to review it. Resources were translated into Spanish at the request of QIA participants.

The Network sent monthly Progress Reports to each dialysis clinic an effort to show clinics real time progress or identify the need for added intervention.

At the conclusion of the project, sustainable practices adopted by clinics included: using Motivational Interviewing and Shared Decision Making when discussing Vascular Access Options with patients, requesting education and vein-mapping prior to discharge for all new-starting patients from the

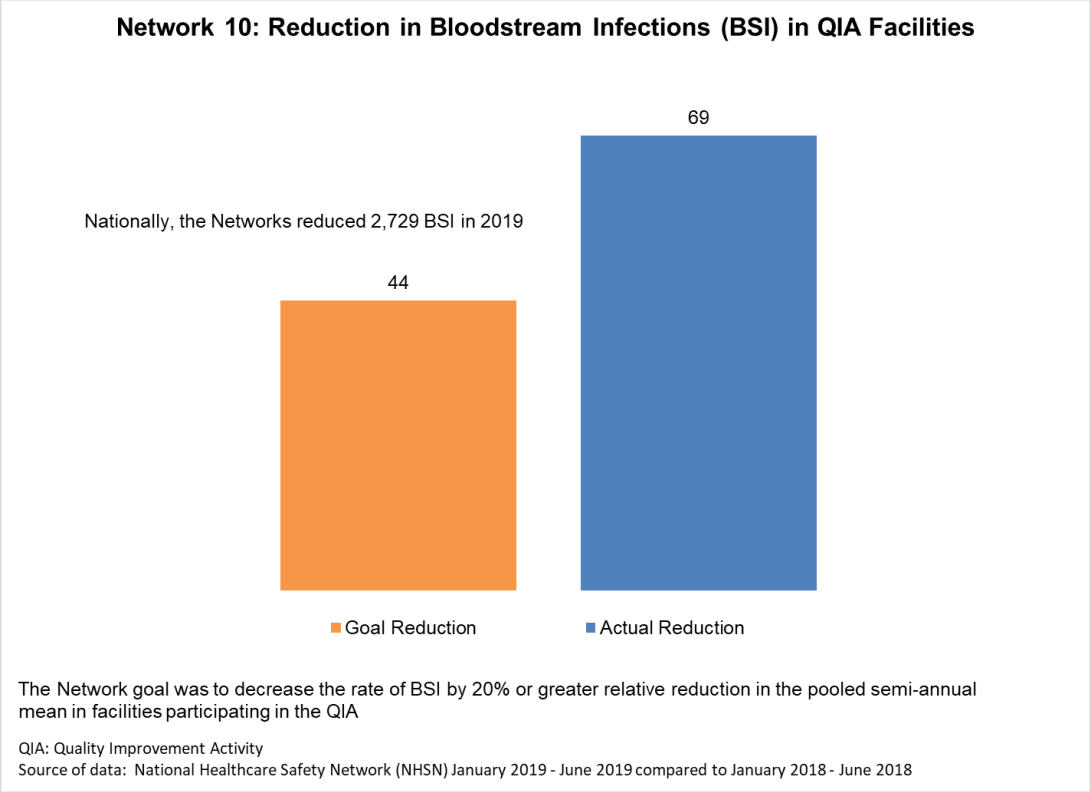
hospital, increased efforts toward educating and making access plans with patients upon admission, and providing reminders and support for vascular access appointments and procedures

Blood-Stream Infection Quality Improvement Activity

The goal of this QIA was to decrease the rate of BSI for 50% of the facilities in the Network 10 service area (158 clinics), with special focus on the 20% (63 clinics) with the highest semi-annual pooled mean bloodstream infection rates from baseline period of January to June of 2018 from the NHSN Excess Infection Report.

Within the special focus project cohort of 63 dialysis clinics, rates of bloodstream decreased from 0.94% down to 0.66%. This result exceeded the project goal, which was to decrease to 0.75%. Network 10 followed the national trend where all Networks reduced the rates of BSI, as shown in Graph 12.

Graph 12



The project began with facilities completing an environmental scan to determine barriers to reducing bloodstream infection. Facilities were next trained in conducting RCA and PDSA methodologies to help them improve processes and to carry out changes which can be sustainable. In support of customer focus, a specific BSI Root Cause Analysis tool was developed and provided to the clinics to help in their RCA efforts. The tool helps staff to determine the root cause of individual catheter or vascular access infections so that a corrective action plan can be developed if trends are identified. Clinics were asked to use the tool with every BSI they reported in NSHN. Each dialysis clinic submitted individual PDSA plans. These were reviewed by Network staff and technical assistance was offered to the participating clinics throughout the project to help in goal attainment.

Each month, a Highlighted Resource was provided with specific resources for staff members and others developed for patients. Hand hygiene audits, using the CDC Core Intervention Audits tools, were a part of the monthly requirements. In addition to staff completing the audits, the Network encouraged the

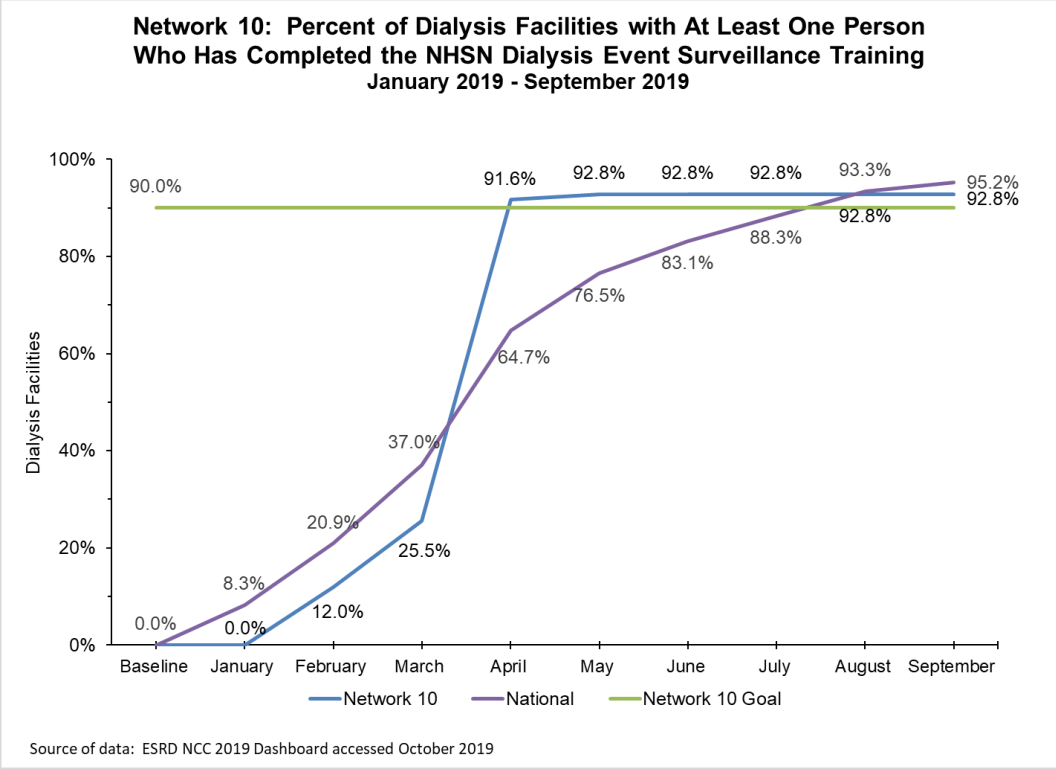
facilities to instruct patients on how to perform hand hygiene audits. At the conclusion of the project, 2,501 hand hygiene audits were completed by patients.

Clinics were encouraged to establish an Infection Control Committee or team in an effort to quickly determine the root cause(s) of patient infections and perform the appropriate steps to accurately document the event into NHSN. Clinics were encouraged to have at least one patient on the committee. The clinics were required to attend CMS-sponsored learning and action network webinars. Elements from each of these LAN meetings were stressed during follow-up with the participating clinics.

At the conclusion of the QIA, facilities reported adoption of the following changes: implementation of daily huddles, initiation of ICHD Infection Control Committees including at least one patient, clinic-wide Infection Prevention Pledges from staff and patients, adopted use of Network BSI RCA tool, regularly scheduled Hand Hygiene in-services for staff and Infection Prevention Lobby Days for patients and families, and adopted use of NCC HAI LAN materials including the Sepsis Early Warning Assessment tool.

NHSN Event Surveillance Training. This QIA had an additional goal for facilities to complete NHSN Dialysis Event Surveillance Training. The Network promoted NHSN Event Surveillance Training for all dialysis clinics in Network 10. Follow up contacts were done throughout the remainder of the project cycle to encourage completion. Network 10 surpassed the goal of 90% facilities completing by achieving 92.8 % training (illustrated in Graph 13).

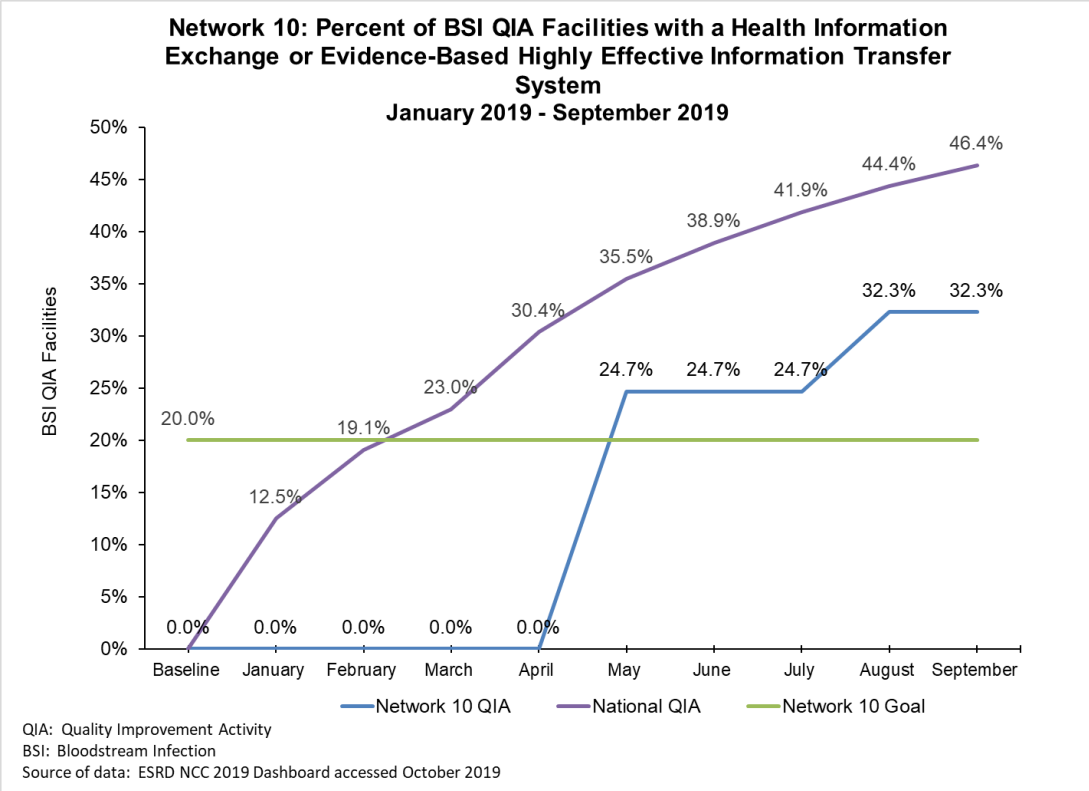
Graph 13



Health Information Exchange. The BSI QIA also included a goal for 20% of the facilities within the cohort to participate in a Health Information Exchange (HIE) or evidence-based highly effective information

transfer system to track bloodstream infections occurring during hospitalizations. The Network brought stakeholders together in an ongoing manner to discuss the importance of communication between hospitals and dialysis providers. Network 10 achieved 32.3 percent of facilities participation, exceeding the project goal of 20%, as shown in Graph 14.

Graph 14

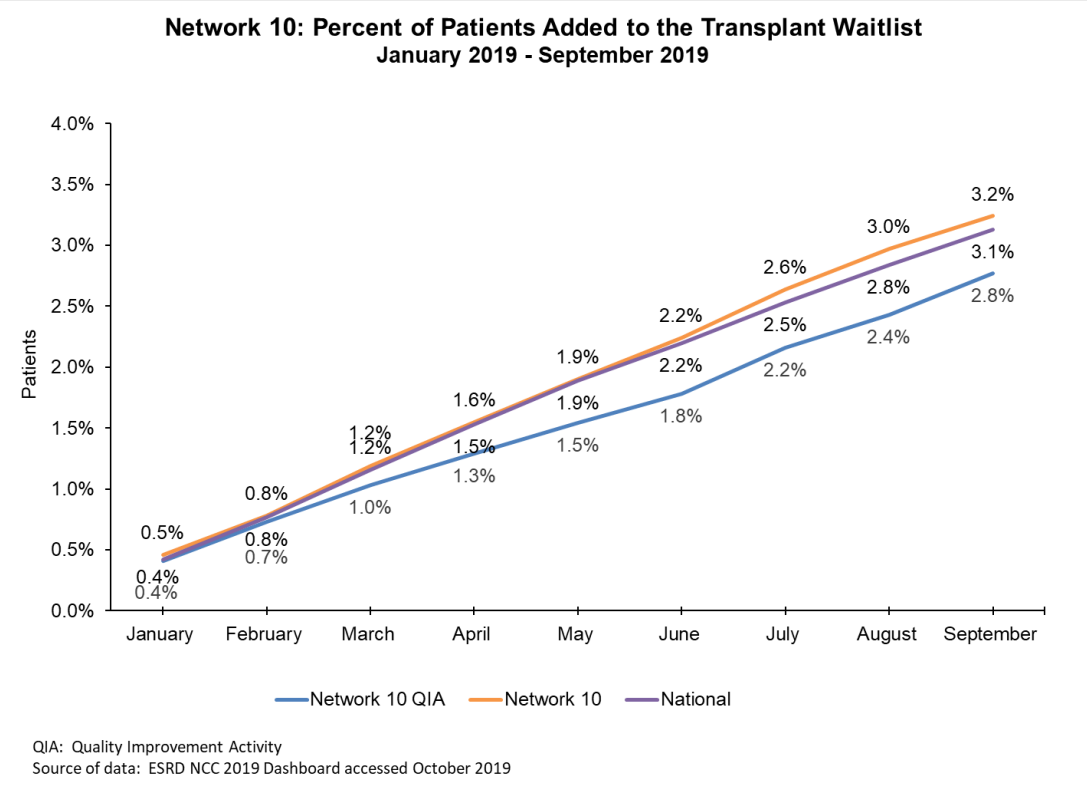


QIA: Quality Improvement Activity
BSI: Bloodstream Infection
Source of data: ESRD NCC 2019 Dashboard accessed October 2019

Transplant Waitlist Quality Improvement Activity

The goal for this project was to demonstrate a 2-percentage point improvement over the natural trend of the Network of patients on the transplant waitlist in 30% of facilities in the Network service area. Nationally, no Networks achieved this goal in 2019; Network 10 achieved a 75.8% toward goal with a 2.4% increase (Graph 15). Although this goal was not fully achieved, within the project cohort of 102 dialysis clinics, 238 patients were added to the transplant waitlist during the QIA period.

Graph 15



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

The project began with facilities completing an environmental scan to determine barriers referring patients to transplant. Barriers identified included: advanced age, lack of insurance, transportation problems to and from the transplant center, lack of social support, comorbidities, poor communication with the transplant center, patient BMI too high, lack of living donor, keeping track of appointments for work-up, patients not interested, patient non-compliance, undocumented patients, lack of understanding of KDPI ranking for cadaver kidneys, and fear of transplant surgery.

These findings from the environmental scan were shared with the transplant centers and Gift of Hope, the organ procurement organization, to help them understand barriers faced by the dialysis clinics. To help the dialysis clinics address the barriers, these topics were used by the Network to develop resources and suggested interventions.

Facilities were trained in conducting RCA and in PDSA methodology to help them improve processes and to carry out changes which can be sustainable. Each dialysis clinic submitted individual PDSA

plans. These were reviewed by Network staff and technical assistance was offered to the participating clinics throughout the project to help in goal attainment.

A Monthly Highlighted Resource was provided with education and technical assistance for staff members and also resources to be shared with patients. The dialysis clinics were required to attend CMS-sponsored learning and action network webinars. Elements from each of these LAN meetings were stressed during follow-up with the participating clinics. Clinics were asked to implement at least one Action Item from each NCC LAN call.

The Network focused heavily on teaching staff how to use Motivational Interviewing to speak to patients about transplant. Shared Decision Making and Relationship Centered Care, along with goal planning sheets for patients and teach-back training were also done within the cohort, with a goal to teach staff the importance of individualized care.

The Network partnered with other transplant professionals and organizations to provide information of value to the dialysis clinics.

Christina Goalby of Health Literacy Media/Explore Transplant presented a webinar to a.) promote health literacy for patients; b.) teach professionals on methods to teach patients the basis about kidney donation and transplant; and c.) apply change theory to improve discussion on transplant and living donations.

Dr. Ed Hollinger, transplant surgeon from Rush University in Chicago, presented a webinar on the steps of the transplant work-up process. This webinar was intended to clarify questions that staff have about the work-up process so that they can better assist patients through the steps to transplant.

The Network met both virtually and in-person with the Illinois Transplant Centers and representatives from Gift of Hope, OPO to share insight from dialysis clinics and patient barriers and discuss ideas for mitigation of common barriers identified during the environmental scan. Many of the barriers are the same issues that have been identified in prior years.

To encourage communication between the Transplant Centers and the dialysis clinics, the Network created a transplant referral tool with staff guidelines for use, requested that clinics invite transplant centers for lobby days, and educated dialysis clinics on the benefits of referral to another program if patients are refused from a program, as not all programs have the same qualifying criteria.

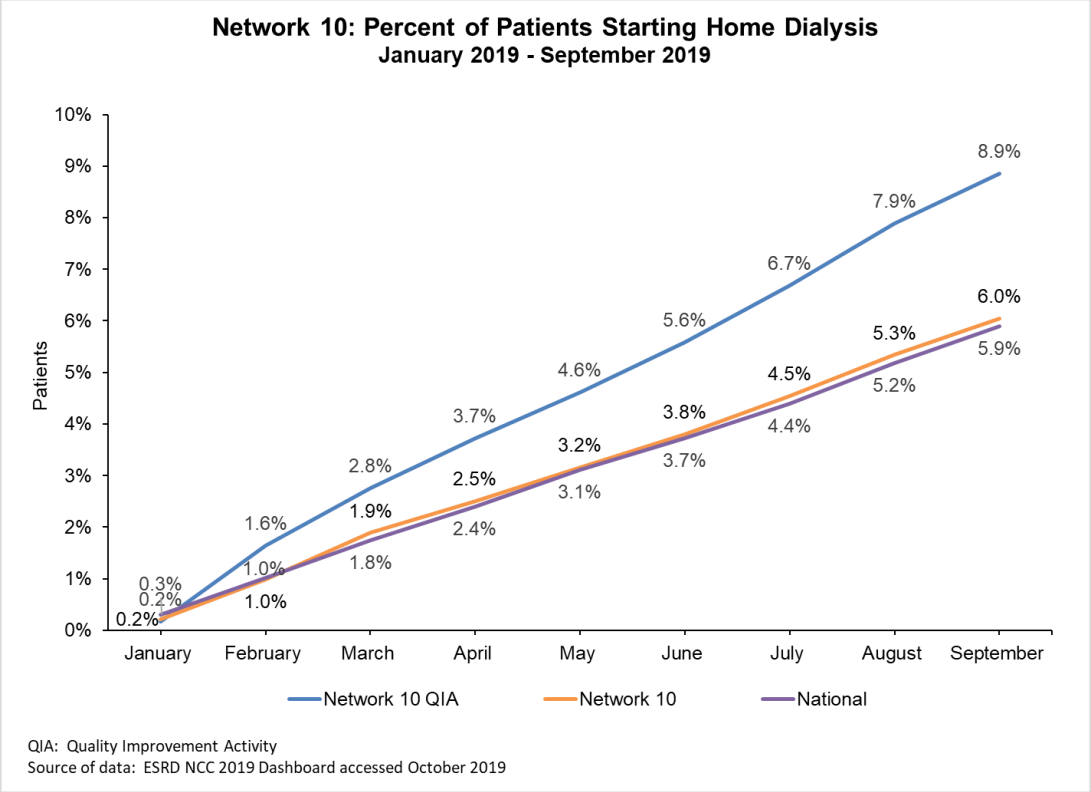
The Network tracked the number of patients educated on transplant each month per facility, as well as the number of patients referred and transplanted.

At the conclusion of the QIA, facilities reported adoption of the following changes: more frequent patient education; expanded methods for education, i.e. bulletin boards, flyers, posters, hearing info from different staff members, apps, and web-based materials; encouraging Nephrologists to speak to patients more frequently about transplantation; inviting transplant centers into the dialysis clinic for lobby days; reviewing transplant candidates in QAPI, including specific barriers; staff training forms to track that all staff are learning about transplant along with patients; heavy focus on staff training in Motivational Interviewing, Shared Decision Making, patient goal planning, and using the "teach back" method to ensure patients understand the information that is being provided.

Home Therapy Quality Improvement Activity

The goal for this project was to demonstrate a 2-percentage point improvement over the natural trend of patients using a home modality of the Network in 30% of facilities in the Network service area. Nationally, ten of 18 networks achieved this goal. Network 10 exceeded the home goal and within the project cohort of 102 dialysis clinics in Network 10, 460 patients initiated home dialysis.

Graph 16



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

The project began with an environmental scan for the facilities to complete to show barriers to referring patients to home dialysis training. Barriers identified included: patients not interested; patients do not understand their options; patients are afraid to take care of themselves; comorbidities; no partner; elderly patients; home space is not big enough; fear of infection based on stories from other patients who failed peritoneal dialysis; patients not given modality education prior to start of HD and don't want to switch; patients comfortable with in-center hemodialysis; and staff not understanding home options and giving poor information that they heard from other patients. The results of the scan were provided to the participating clinics to help in their improvement efforts. The results were also used by the Network to find, or develop, resources to help dialysis clinics overcome these barriers.

Facilities were next trained in conducting RCA and in PDSA methodologies to help them improve processes and to carry out changes which can be sustainable. Each dialysis clinic submitted individual PDSA plans. These were reviewed by Network staff and technical assistance was offered to the participating clinics throughout the project to help in goal attainment.

A Monthly Highlighted Resource was provided with education and technical assistance for staff members and also resources to be shared with patients. The dialysis clinics were required to attend

CMS-sponsored learning and action network webinars. Elements from each of these LAN meetings were stressed during follow-up with the participating clinics. Clinics were asked to implement at least one Action Item from each NCC LAN call.

The Network focused heavily on teaching staff how to use Motivational Interviewing to speak to patients about home modalities. Shared Decision Making and Relationship Centered Care, along with goal planning sheets for patients and teach-back training were also done within the cohort, with a goal to teach staff the importance of individualized care.

At the conclusion of the QIA, facilities reported adoption of the following changes: sponsoring a "Feel the Difference" lobby day with a focus on NxStage; home dialysis nurse visiting the clinic and speaking to the patients at chairside; increased use of modality educators; continued exploration and implementation of transitional care units; many clinics reported using the MATCH-D tool from the Medical Education Institute as a screening tool for all of their patients, which was provided by the Network as one of the monthly Highlighted Resources; increased focus on staff training in Motivational Interviewing, Shared Decision Making, patient goal planning, and using the "teach back" method to ensure patients understand the information that is being provided; and use of the web based modality decision tool from MEI, My Life, My Dialysis Choice to assist patients with identifying the best modality for their individual lifestyle.

Population Health Focus Pilot Project Quality Improvement Activity

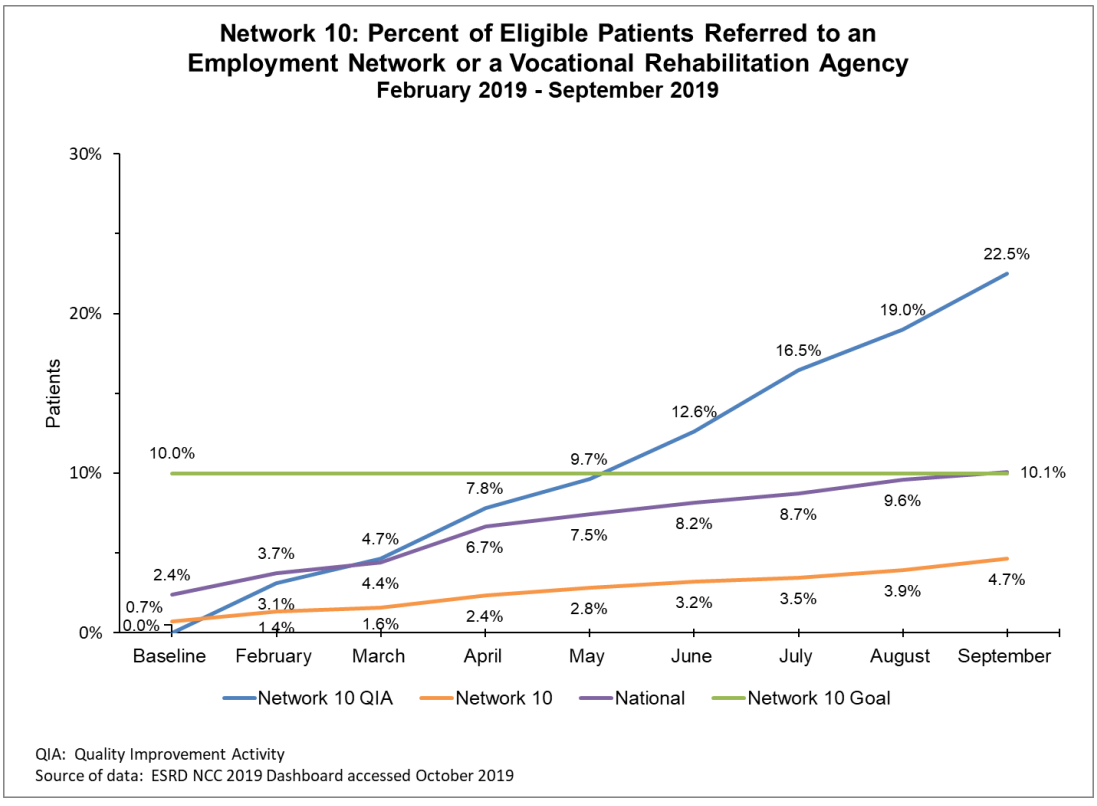
Network 10 chose to participate in QIA C: Support Gainful Employment of ESRD Patients. The intent of this QIA was to assist ESRD patients with seeking gainful employment and/or returning to work which entailed a three-part goal:

1. Provide technical assistance to dialysis facilities in the cohort (n=35) with developing a process to ensure that 100% of patients are screened for interest in vocational rehabilitation services and that response is documented in CROWNWeb.
2. Achieve a 10-percentage point increase in referrals of eligible patients to Employment Networks or VR services (Graph 17). Network 10 surpassed this goal for referral of eligible patients, starting from 0% at baseline and increasing to 22.5% at remeasurement.
3. Demonstrate at least a 5-percentage point improvement in the number of referred eligible patients receiving EN or VR services by close of the QIA measurement period. Network 10 also exceeded this goal with a 10.3% increase in referred eligible patients receiving services (Graph 18).

Eligible patients include those that are:

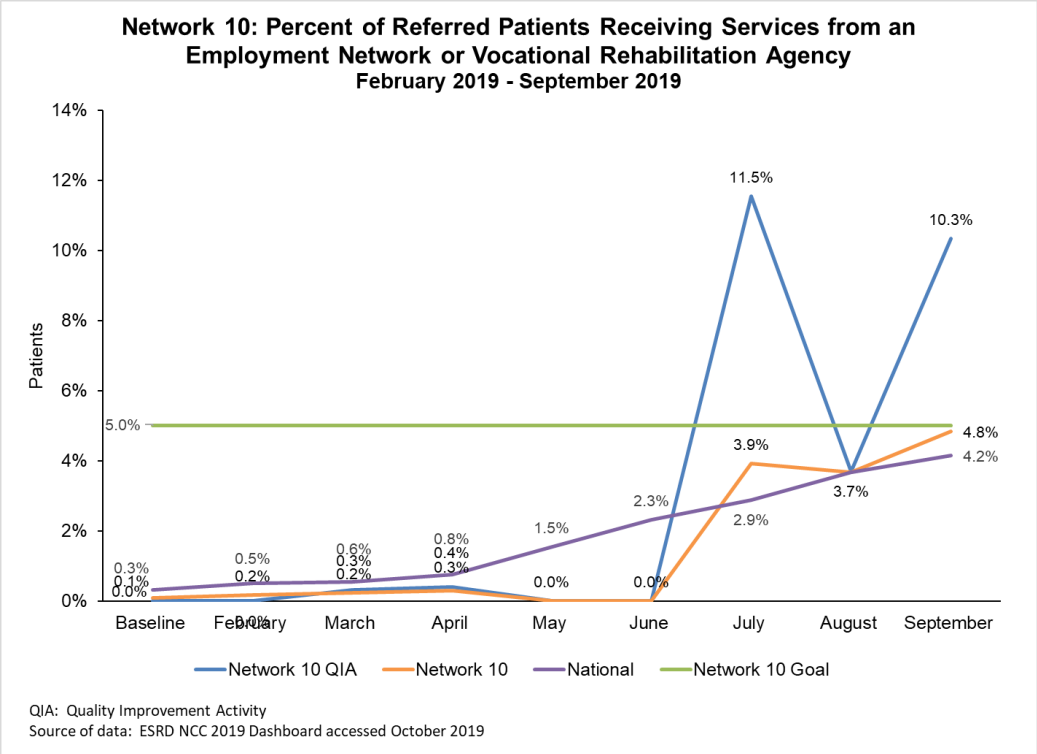
- Between the ages of 18-55
- Blind or have a disability AND receive Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) benefits
- Not currently employed, in school or receiving specialized training
- Interested in receiving vocational rehabilitation services

Graph 17



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

Graph 18



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

A Root Cause Analysis was performed at the start of the QIA, identifying the Top 3 Issues:

1. Lack of understanding on part of clinic staff on how to assess and document VR status in CROWNWeb
2. Lack of patient understanding about how SSI/SSDI benefits will be affected if they return to work
3. Poor communication pathways and/or identification of resources with VR/EN agencies

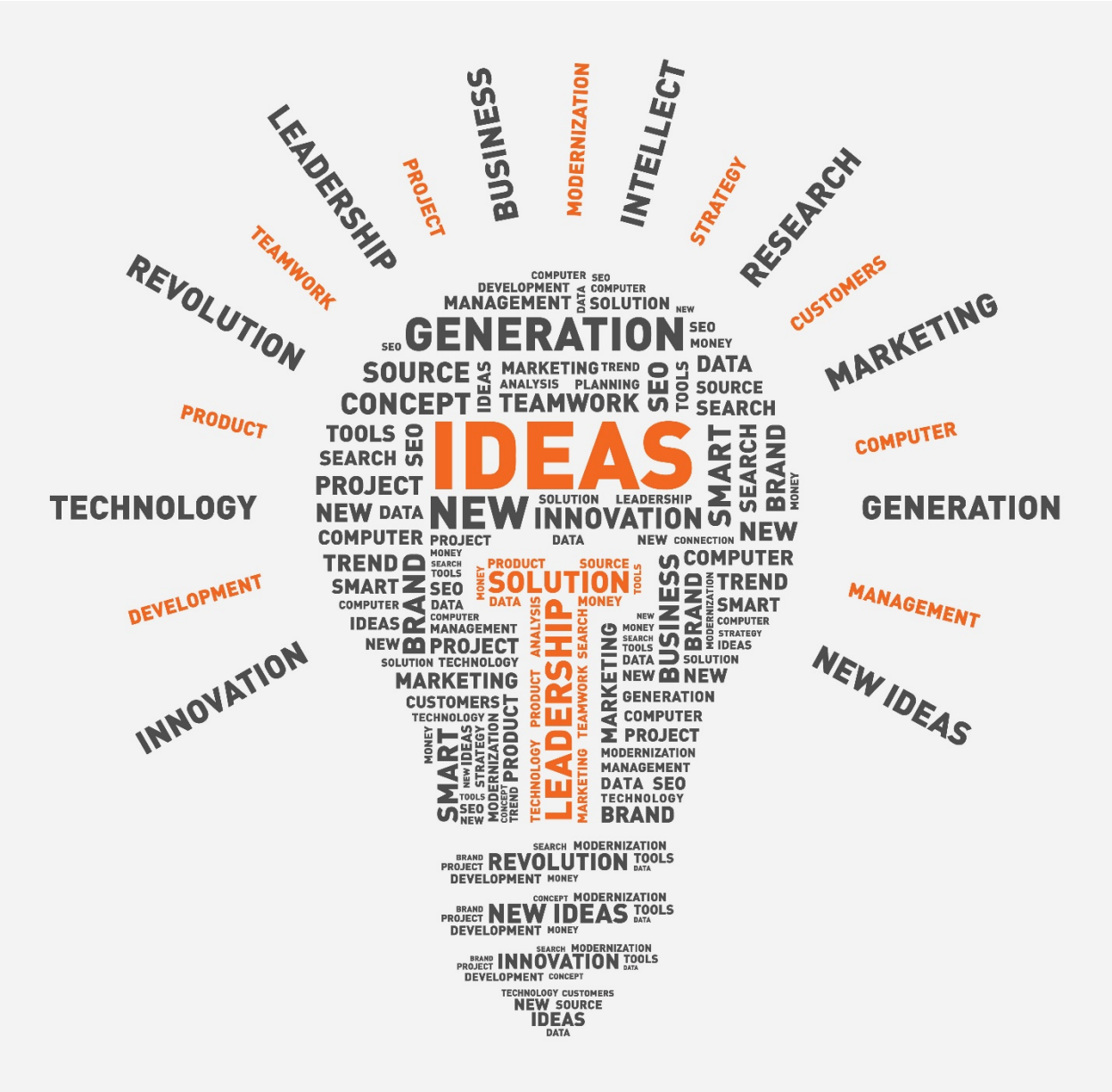
The Network provided technical assistance to facilities including a tutorial for documenting VR status in CROWNWeb, a recorded walk-through on how to complete this documentation correctly, a Best Practices checklist for evaluating patients for Vocational Rehabilitation, and a conversation starter and goal planning sheets to help patients set SMART goals toward returning to work. Network 10 also focused on patient education about federal and state programs for returning to work, stories from patients who have used VR services for work or school, and information on how working and staying active can benefit patient health.

The Network also focused on teaching staff how to use Motivational Interviewing to speak to patients about modality choices that better support patients returning to work such as home dialysis or transplant. Shared Decision Making and Relationship Centered Care, along with goal planning sheets for patients and teach-back training were also done within the cohort, with a goal to teach staff the importance of individualized care.

Clinics were required to complete Sustainability Plans to help ensure that their process changes would become part of their daily, weekly, or monthly routines and that progress would be maintained for the betterment of patient care. In order for the Network to assess areas for improvement and to encourage

patient engagement, patients in the cohort clinics were asked for their opinions on the most beneficial resources. Final Evaluations for staff project leads were also completed at the wrap-up of the project in order to provide suggestions for improvement for future projects.

ESRD NETWORK RECOMMENDATIONS



RECOMMENDATIONS FOR SANCTIONS, SERVICES, AND/OR FACILITIES

ESRD Network 10 made no recommendations for sanctions during 2019.

ESRD Network 10 made no recommendations for new services during 2019.

ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION

The Network is a resource for its providers during disasters. The Network routinely contacts dialysis units within areas where disasters have been reported, such as floods, tornadoes, snowstorms, water issues, and power outages. Network 10 has an emergency back-up agreement in place with ESRD Network 6 in the event the Network office would close.

During 2019, the Network responded to ten individual facility-specific or regional emergencies, including:

- Snow/Winter Storm (three separate occurrences)
- Temporary Closure due to Construction/Maintenance
- Plumbing Issues (two separate occurrences)
- Water System Break
- Water Main Break (three separate occurrences)

During disaster events in 2019 in ESRD Network 10, facilities were contacted by Network staff to monitor their open and closed status and to offer Network assistance. The open and closed status of affected facilities was provided to the CMS Regional Office.

The Network staff worked throughout the year to remind facilities of their role in the event of an emergency or disaster. The Network routinely sends emergency preparedness information to all facility administrators prior to impending storms. The information provides disaster preparedness resources for patients and staff. Reminders to update facility disaster plans are included with the information sent.

On November 7, 2019, Network staff participated in an emergency preparedness drill led by the KCER Coalition. The drill simulated a technological and natural disaster involving winter storms and transportation disruption. The goal of the exercise was to test Network level emergency response plans, policies and procedures as they would pertain to such a disaster. The Network staff held meetings to

assess the situation and made decisions on how to remain functional despite the challenges presented by the hypothetical situation.

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.