

ESRD NETWORK 2019 ANNUAL REPORT

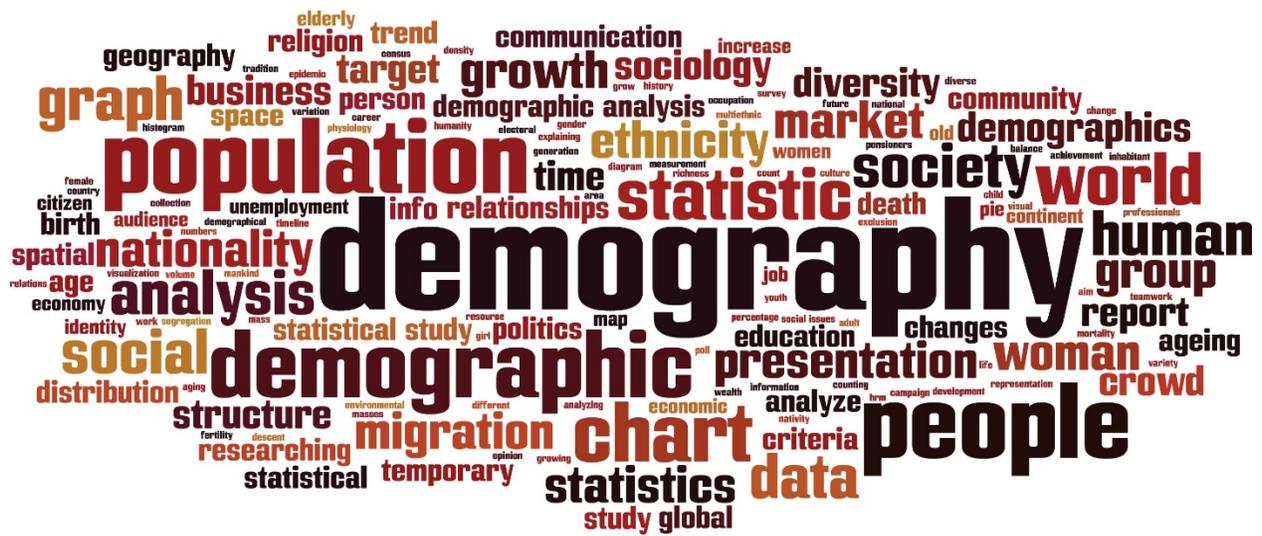
Health Services
Advisory Group
(HSAG): End Stage
Renal Disease
(ESRD) Network 13

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ESRD DEMOGRAPHIC DATA

ESRD Network 13

As part of the Health Services Advisory Group (HSAG) team, Network 13 works with patients, providers, and stakeholders in the states of Arkansas, Louisiana, and Oklahoma to promote the highest quality healthcare, improve patterns of healthcare delivery, and protect Medicare rights for the ESRD patients in its service area. HSAG has held the Network 13 contract since 2013.

Geography and General Population

The Network 13 service area encompasses three states with a contiguous landmass that covers approximately 165,000 square miles and includes swamp, coastal marshes, barrier islands, river valleys, forests, sub-tropical forests, lakes, bayous, arid plains, and mountains. Oklahoma contains 10 distinct ecological regions, more per square mile than in any other state by a wide margin. As of July 1, 2018, the Network 13 service area had a combined estimated general population of 11,616,882. These data were obtained from the U.S. Census Bureau, 2018.

ESRD Population

Network 13 worked in collaboration with the renal community and other key stakeholders to improve the quality of care and quality of life for 27,709 ESRD patients in 2019 based on data collected from CROWNWeb in the Network's service area. (see Chart A) In 2019, 5,319 individuals were newly diagnosed with ESRD. (see Chart B)

Race and Ethnicity¹

As of December 31, 2019, the demography of the ESRD population in the Network 13 service area reflected the following:

- White: 46.6%
- Native American: 3.4%
- African American: 48.0%
- Hispanic or Latino: 4.3%

Gender and Age

As of December 31, 2019, 43.7% of the Network's ESRD population was female, 55.1% was male, and 43.7% was age 65 or older, as compared to the service area's general population, in which only 15.5% of residents were estimated to be age 65 or older as of July 1, 2018. (U.S. Census Bureau, 2018)

Dialysis Treatment Options

According to CROWNWeb data, and as of December 31, 2019, Network 13 had 21,344 ESRD patients on dialysis receiving treatment across the 343 Medicare-certified dialysis facilities, one federal prison, and one Veterans Administration provider across its region. Four main modalities of dialysis treatment were being used (see Chart C):

- In-center hemodialysis (ICHHD): 85.4%
- Continuous-cycling peritoneal dialysis (CCPD): 11.0%
- Continuous-ambulatory peritoneal dialysis (CAPD): 1.1%
- Home hemodialysis (HHD): 2.5%

¹ Data on "ethnicity" and "race" should be interpreted with caution because of the inherent instability of race/ethnicity data.

Chart A: Count of Network Prevalent ESRD Patients by Treatment/Setting for 2019

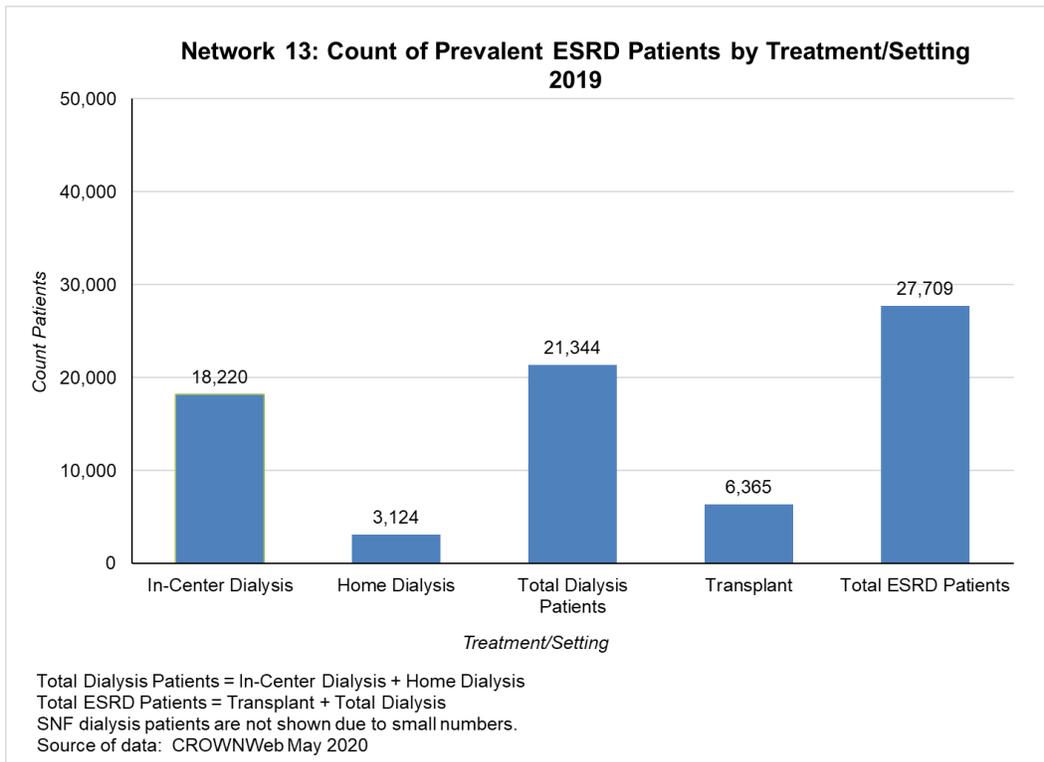


Chart B: Count of Network Incident ESRD Patients by Initial Treatment/Setting for 2019

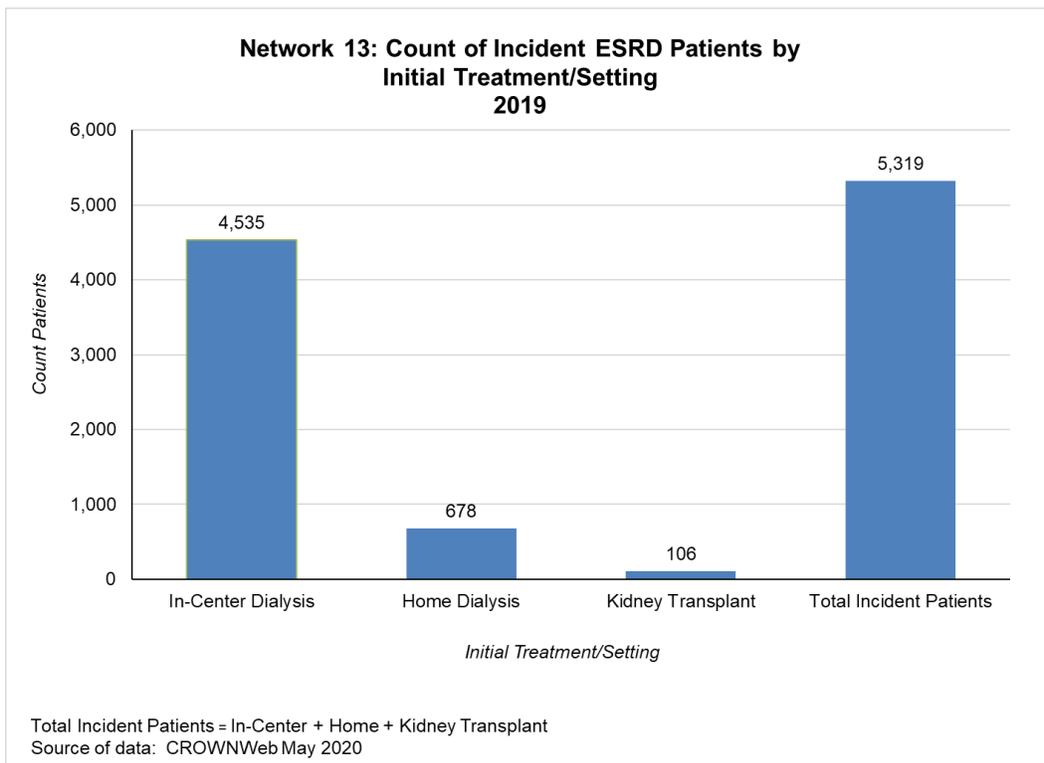


Chart C: Count of Network Medicare-Certified Facilities by Treatment/Setting for 2019

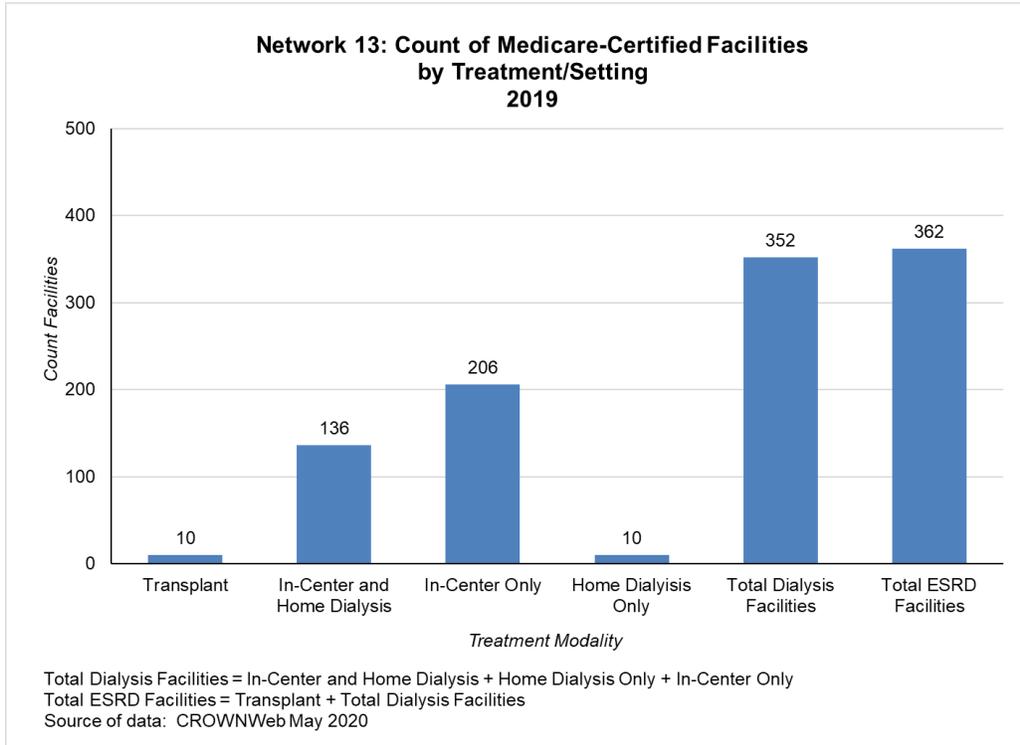


Chart D: Percent of National Prevalent Dialysis Patients by ESRD Network for 2019

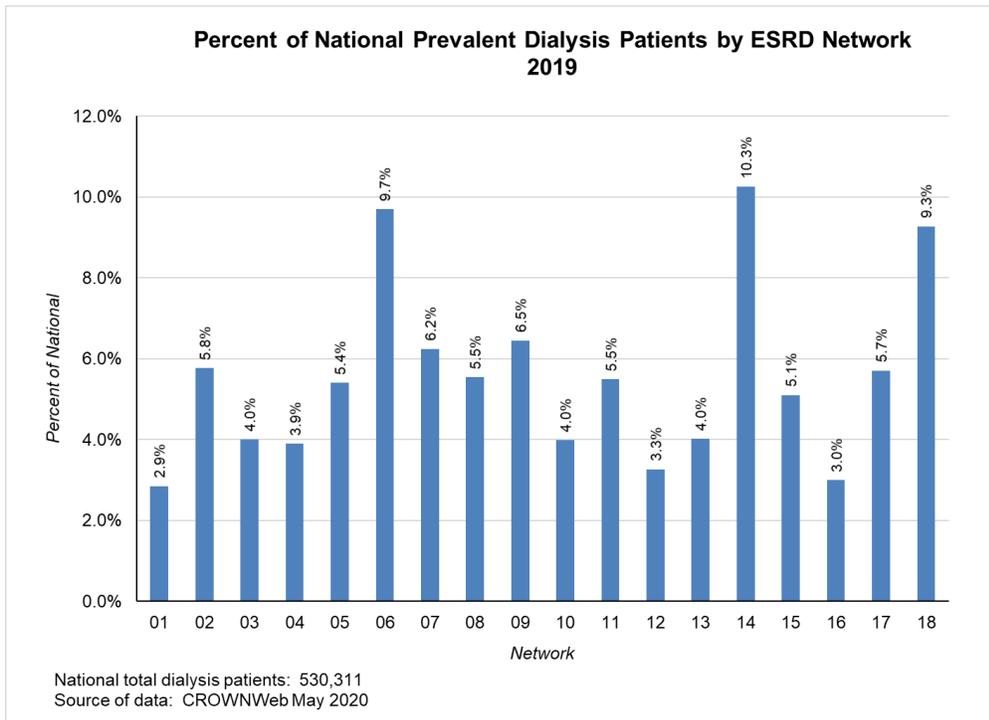


Chart E: Percent of National Incident Dialysis Patients by ESRD Network for 2019

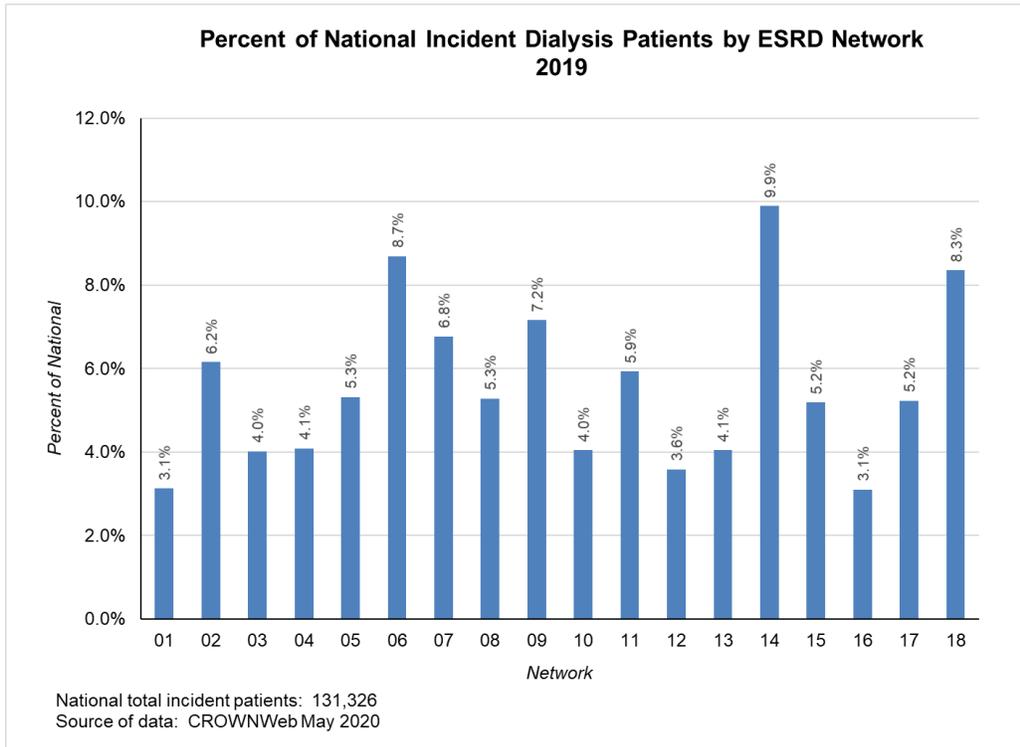


Chart F: Percent of Medicare-Certified Dialysis Facilities by ESRD Network for 2019

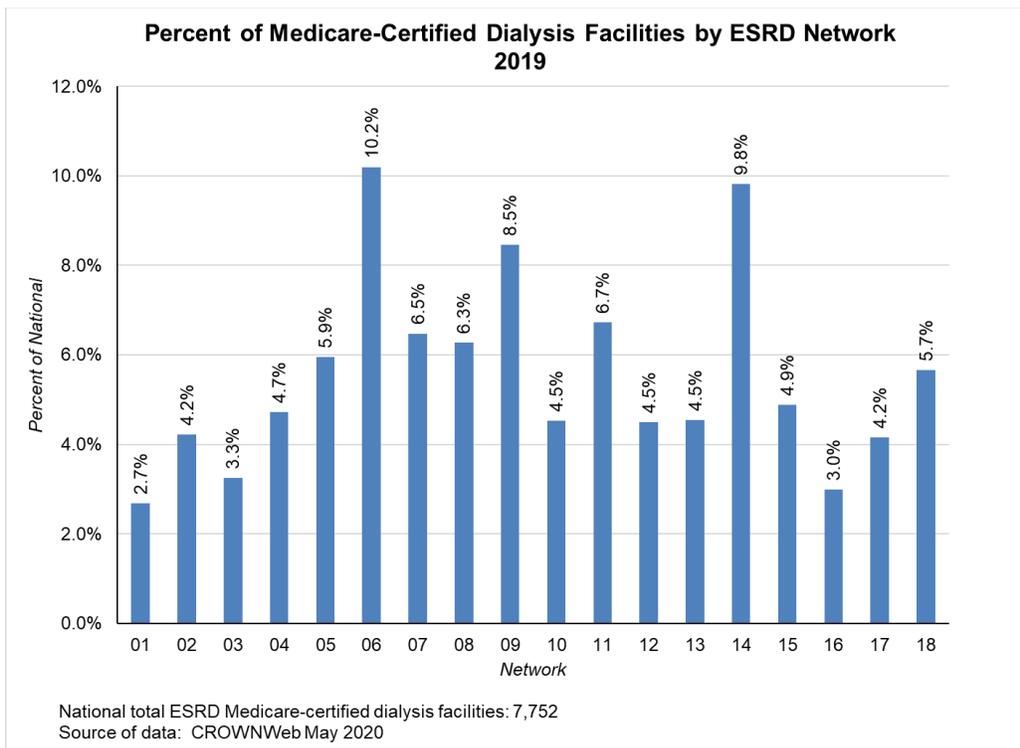


Chart G: Percent of National Home Hemodialysis and Peritoneal Dialysis Patients by ESRD Network for 2019

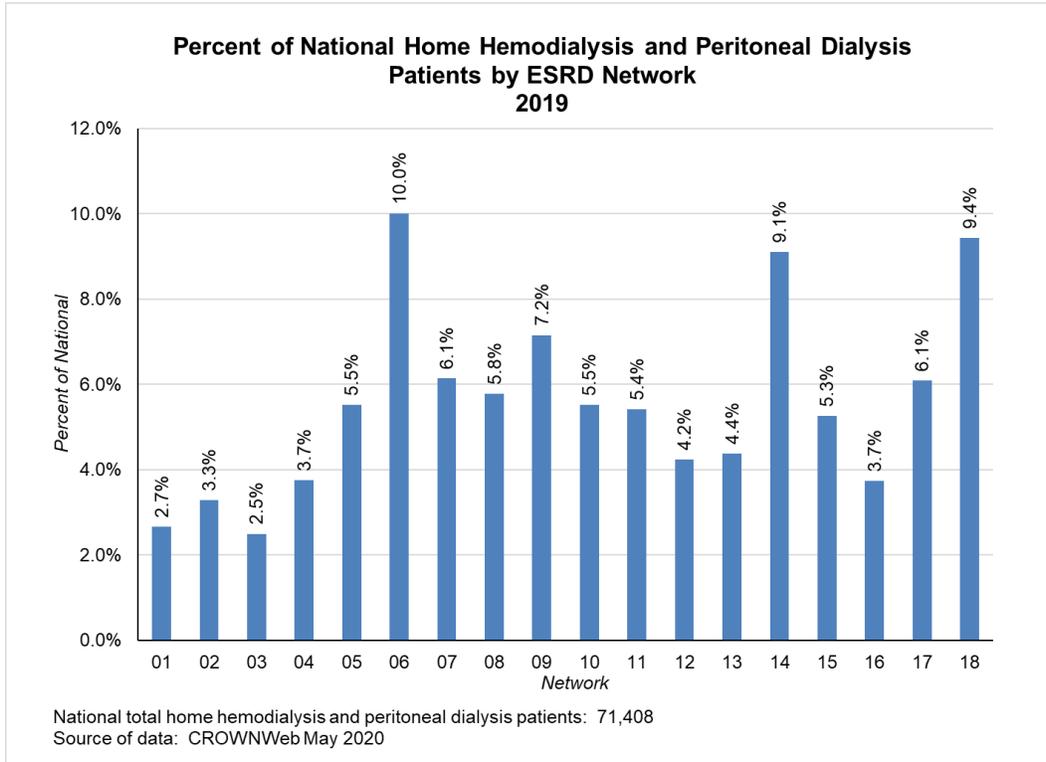


Chart H: Percent of National Transplant Patients by ESRD Network for 2019

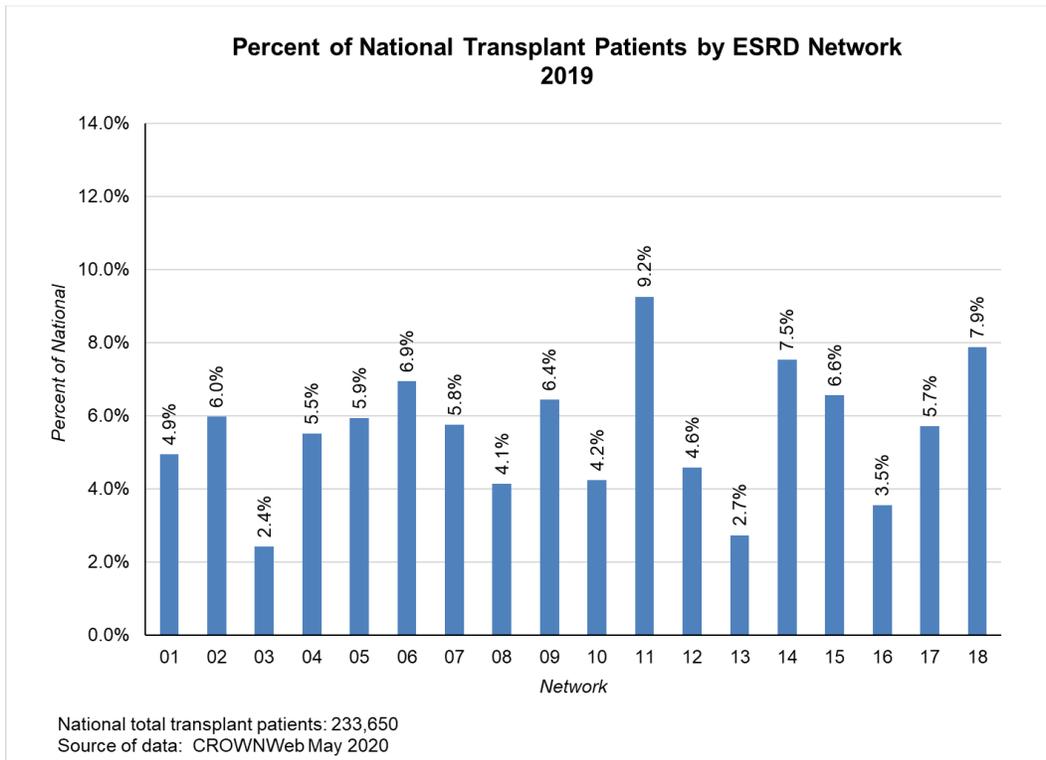
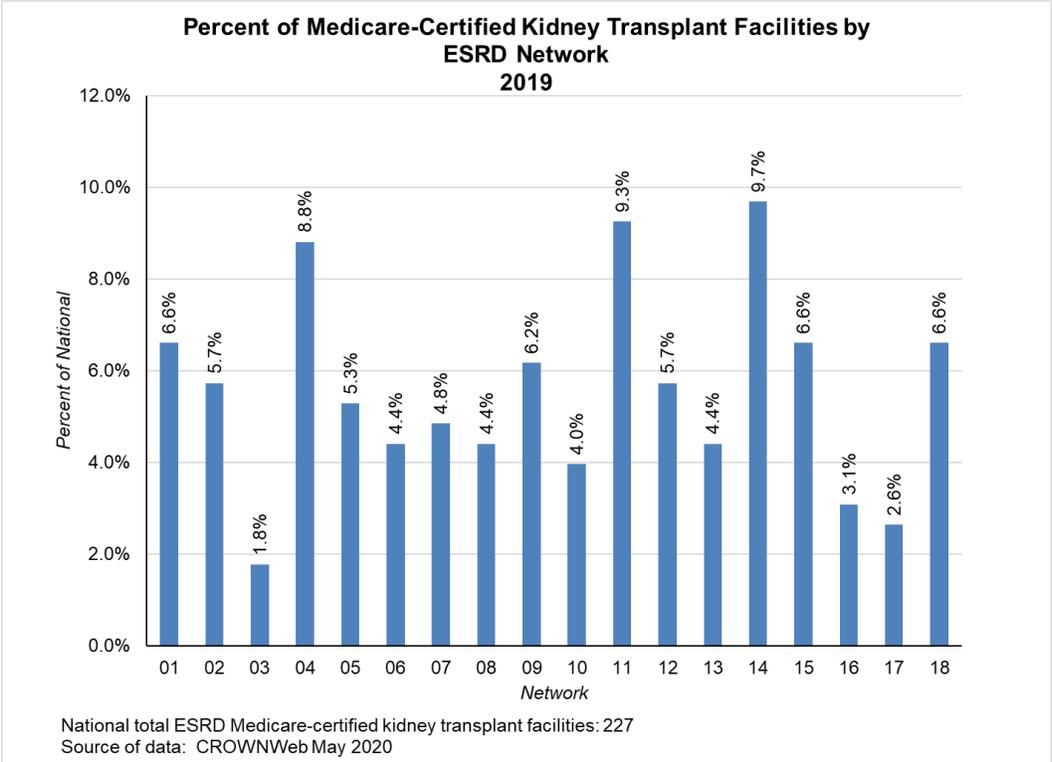


Chart I: Percent of Medicare-Certified Kidney Transplant Facilities by ESRD Network for 2019



ESRD NETWORK GRIEVANCE AND ACCESS-TO-CARE DATA

Improving the Grievance and Access-to-Care Processes

In April and October 2019, the Network conducted two focused audits to gauge internal and external issues in the areas of grievances and access to care. Additionally, the Network sought to improve its grievance satisfaction scores toward meeting national satisfaction expectations. All quality improvement (QI) activities were carried out with input from patient subject matter experts (SMEs).

Goals and Outcomes

The goals for QI activities in patient services were to decrease the number of grievance and access-to-care cases (see Chart J), while raising the Network's performance for the national grievance satisfaction survey outcomes. General grievances declined from 8.0% in 2018 to 6.0% in 2019. Access-to-care issues decreased from 36.0% in 2018 to 28.0% in 2019.

Interventions

The interventions were designed to assist facilities with using a grievance process to efficiently handle patient concerns related to environmental, interpersonal, and operational issues. Likewise, interventions to improve access-to-care processes were implemented to facilitate interactions to prevent and/or avert involuntary discharges (IVDs) and/or transfers (IVTs). Technical assistance was provided to assist with failure-to-place (F2P) challenges regarding permanent chronic dialysis unit placement for patients with complex issues. Focused-area interventions included:

- General grievance education for both providers and patients, including:
 - Provision of state-specific grievance posters with Network and State Survey Agency (SA) contact information to all existing and new ESRD providers.
 - Posting of this information in patient waiting areas is required and verified by onsite visits.
 - Provision of guidance highlighting definitions and responsibilities regarding grievances.
 - Additional resources for ESRD providers.
 - Utilization of the Forum of ESRD Networks' *Grievance Toolkit: Fostering Communication & Improving Quality*.
- Implementation of access-to-care processes, including:
 - Use of an IVD checklist to ensure that all required process steps are addressed by providers when handling IVD/IVT cases.
 - Quarterly interactions between the Network and the SAs, as applicable, specific to access-to-care cases.
 - Interactions included facility-reported discharge reasons and case-specific outcomes.
 - Correspondence with facility administrators and medical directors regarding IVD, with an emphasis on physician discharge.
 - Dissemination of article about IVD and IVT in the Network's patient and provider newsletters that focused on addressing psychosocial interventions.

The Network reviewed a root cause analysis (RCA) and revisited its Plan-Do-Study-Act (PDSA) plan to identify any new issues and strategies. Activities continued toward enhancement of the Network's improved grievance satisfaction scores through 2019. Highlights from the PDSA cycle included:

- Plan: The Network determined that sending follow-up notecards to check in with grievants 15 days after case closure was effective in letting grievants know that they had support, even after their issues had been resolved.

- Do: The Network sends the Forum of ESRD Networks' Grievance Toolkit with the grievance acknowledgment letter instead of the case closure letter.
 - Previous interactions proved that sending toolkit at the beginning of the grievance better helps patients with navigating the grievance process.
- Study: Baseline-to-final available grievance satisfaction survey scores reflect ongoing improvement throughout 2019.
- Act: A critical component of Network 13's customer service includes ongoing education of patients who file a grievance regarding that which is within the Network's ability to assist, as well as items that the Network has no control over, including "firing clinicians that they don't like."

Best Practices

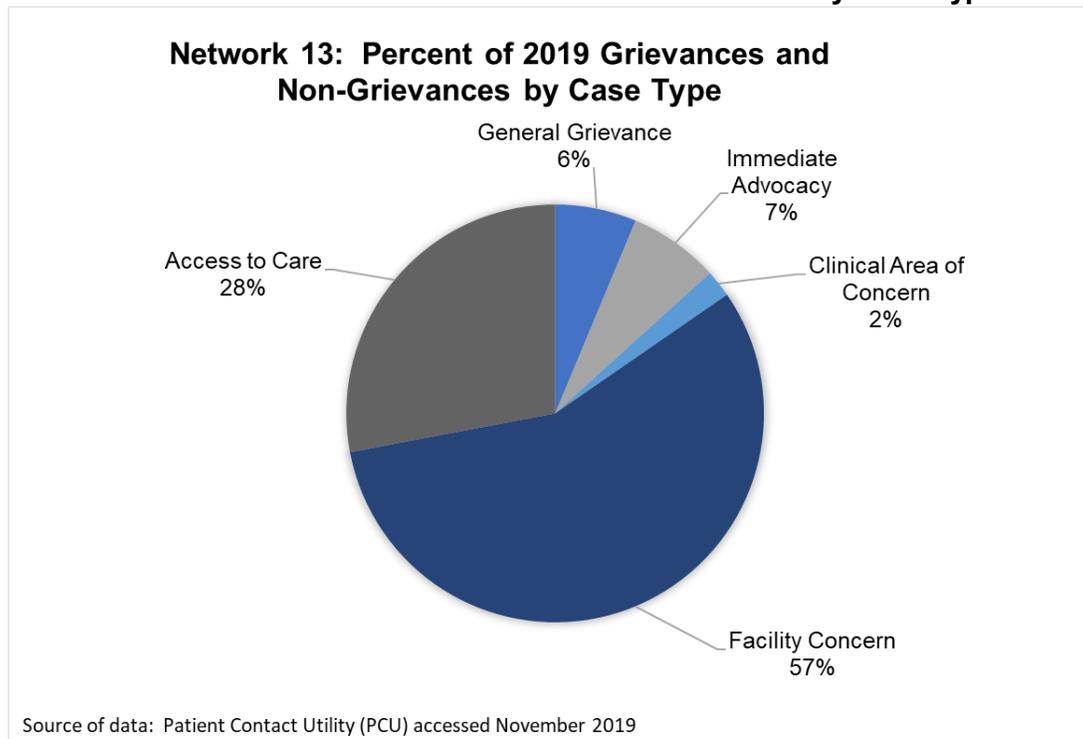
- Ongoing education addressing the importance of maintaining consistent practices, processes, and protocols.
- Use of distributed sustainability worksheet reflecting solid processes to address grievances in a proactive versus reactive manner.

Barriers

Ongoing barriers to improving patient grievance satisfaction scores include:

- Lack of consistent communication between patients and facility staff related to grievances.
- Staff turnover among the clinicians who generally handle grievances, such as social workers and nurse managers, which leads to knowledge deficits and inconsistencies in practice.

Chart J: Percent of 2019 Grievances and Non-Grievances by Case Type



ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA

Long-Term Catheter (LTC) Quality Improvement Activity (QIA)

During 2019, the Network conducted a QIA to reduce LTC use (catheter in use for 90 days or longer) within a cohort of 67 facilities with LTC rates greater than 15.0%. The Network implemented enhanced interventions for a subset of 26 facilities, with approximately 1,480 patients, which had the highest LTC rates in the cohort.

Goals and Outcomes

The baseline LTC rate for this activity was 17.5%, generated from June 2018 CROWNWeb data. The goal was to reduce the rate of LTC use by two percentage points from baseline. By July 2019, the group reduced the aggregate LTC rate to 15.9%, a 1.6 percentage-point reduction, as seen in Chart K.

Barriers

The following barriers to reducing LTC use were identified based on facility RCA results:

- Patient refusal for permanent access placement due to multiple failed surgeries and needle fears.
- Surgeon issues.
 - Long wait times, limited availability, cancelled surgeries
- High number of incident (new) catheter-only admissions with difficulty getting the LTCs removed within 90 days.

Interventions

Facility-specific interventions for the QIA included:

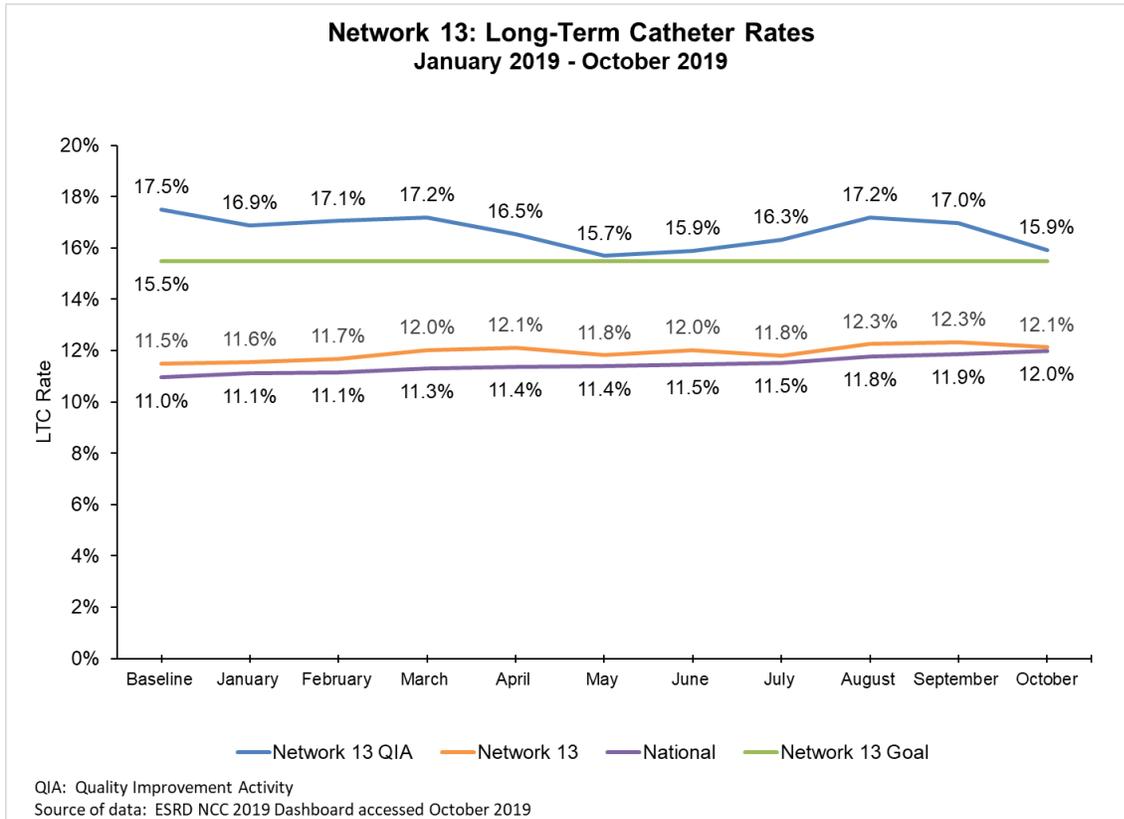
- Initiating an RCA and developing an action plan to decrease LTCs based on findings.
- Attending and participating in the Network 13 vascular access (VA) education activity, *Strategies to Reduce Catheter Use*.
- Providing patient education through VA bulletin boards, Lobby Days, and other resources, such as catheter complication puzzles, which were developed in collaboration with the membership of Network 13 Patient Advisory Committee (PAC), and *Fistula First* materials that provided information on permanent vascular access types.
- Assessing patient improvements in knowledge by providing patients with the *Patient Vascular Access Checklist*, a 10-question quiz about VA, performed at QIA initiation and completion.

Best Practices

Best practices identified by QIA facilities included:

- Conducting a Catheter Reduction Lobby Day.
- Ordering antibiotic ointment for catheter packs to be applied per policy to all catheter sites unless allergy contraindication.
- One-on-one teaching with patients rather than just handing out flyers and information sheets.
- Referring to vascular surgeons within the first week of patient admission to the dialysis facility to ensure every patient with a central venous catheter (CVC) has a permanent vascular access plan or documented refusal.
- Training the administrator as a vascular access manager to devote more time to vascular access management.
- Creating an expert cannulator program; inclusive of an in-service on how to prevent “one-site -it is.”
- Hiring a vascular access manager for evaluation, appointments, referrals, and scheduling.

Chart K: Long-Term Catheter Rates Between January 2019 to October 2019 for the Network QIA, Network, Nation, and Network Goal.



Bloodstream Infection (BSI) Quality Improvement Activity

In 2019, the Network conducted a QIA to reduce BSIs by improving infection control practices. The QIA was designed to support the National Action Plan to Prevent Healthcare-Associated Infections (HAIs) and the Centers for Disease Control and Prevention (CDC) Core Interventions for Dialysis Bloodstream Infection Prevention. The QIA included 67 facilities, impacting 5,054 patients.

Goals and Outcomes

The Network used the National Healthcare Safety Network (NHSN) BSI pooled mean rate per 100 patient-months to target facilities for the QIA. The goal was to demonstrate a 20.0% or greater relative reduction in pooled mean BSI rate and to prevent at least 55 BSIs. By QIA completion, the aggregate BSI rate decreased from 1.2 BSIs per 100 patient-months to 0.7, and 127 BSIs were prevented, thereby successfully exceeding established goals of reduction and prevention. (see Chart L)

Barriers

Facilities reported the following barriers to further reducing BSIs:

- Patients did not follow hand-hygiene practices upon entering and leaving the treatment floor.
- Patients did not wash their vascular access.
- Staff did not monitor and/or adhere to infection control processes.

Interventions

Interventions implemented during the QIA included:

- Initiating an RCA and developing an action plan to decrease BSIs based on findings.
- Providing facility education on the:
 - CDC's BSI Dialysis Collaborative Core interventions, tools, and resources.
 - The importance of having a front-line clinician complete the annual CDC/NHSN Dialysis Event training. (See Chart M)
 - Establishment and utilization of a secure health information exchange (HIE) process for sharing blood culture results across healthcare settings (i.e., acute dialysis units, hospitals), as seen in Chart N.
- Completing monthly performance audits, inclusive of practice issues specific to hand hygiene, connecting and disconnecting catheters, and cannulation of fistulas or grafts.
- Completing and submitting the monthly Infection Data Collection Tool, including monthly PDSA cycle updates.
- Participating in the HAI Learning and Action Network (LAN) bi-monthly calls.
- Conducting outreach, such as creating a hand hygiene bulletin board, hosting a Lobby Day on Infection Prevention, and posting the CDC's *Days Since Last Bloodstream Infection* poster.
- Assessing and encouraging patient/family engagement and sharing of the patient perspective on infection control processes by:
 - Recruiting Network Patient Representatives (NPRs).
 - Assessing patient improvements in knowledge by providing patients with the Patient Access Infection Checklist about infection control processes at QIA initiation and completion.
 - Educating patients using patient "preventing infection" pledges, articles, and puzzles.
- Conducting a sustainability survey at the conclusion of the QIA for the continuation of improvement and best practices.
- Assisting facilities with enrollment and use of the NHSN for training regarding dialysis-event reporting for internal, comparative reporting QI purposes.

Best Practices

Best practices identified by QIA facilities included:

- Implementing use of Personal Antimicrobial Wipes Safetec (P.A.W.S.)[®] antimicrobial hand wipes.
- Involving patients with the completion of CDC audits.
- Having physicians perform hand hygiene audits.
- Using the CDC *Days Since Last Infection Poster* for staff and patients to see and track performance.
- Providing the Network article, *Beware of the Summer Bloom*, to patients which highlights increased risk of infection due to warm weather and prevention tips.
- Using the CDC's handout, *Conversation Starter to Prevent Infections in Dialysis Patients*.
- Initiating a patient monthly newsletter for dialysis with sections on hand hygiene, infection control, and access care.
- Hosting a balloon celebration for BSI-free days.
- Sending the *Dialysis Center Report* to the hospital infection preventionist or to the acute dialysis unit when a patient is admitted to hospital.

Chart L: Reduction in Bloodstream Infections in Network QIA Facilities

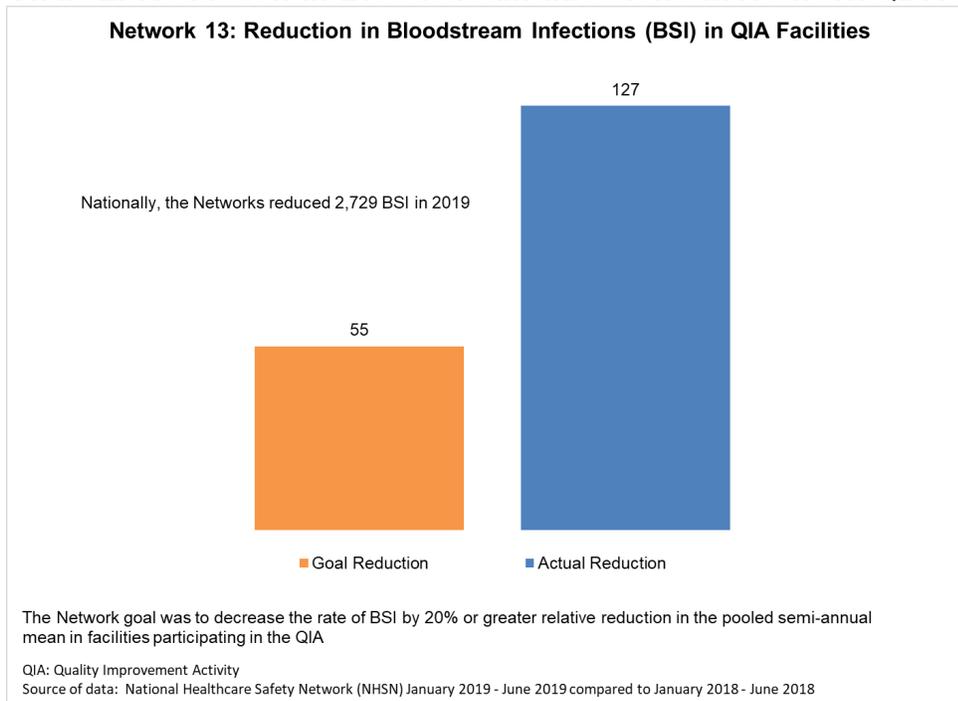


Chart M: Percent of Dialysis Facilities with At Least One Person Who Has Completed the NHSN Dialysis Event Surveillance Training

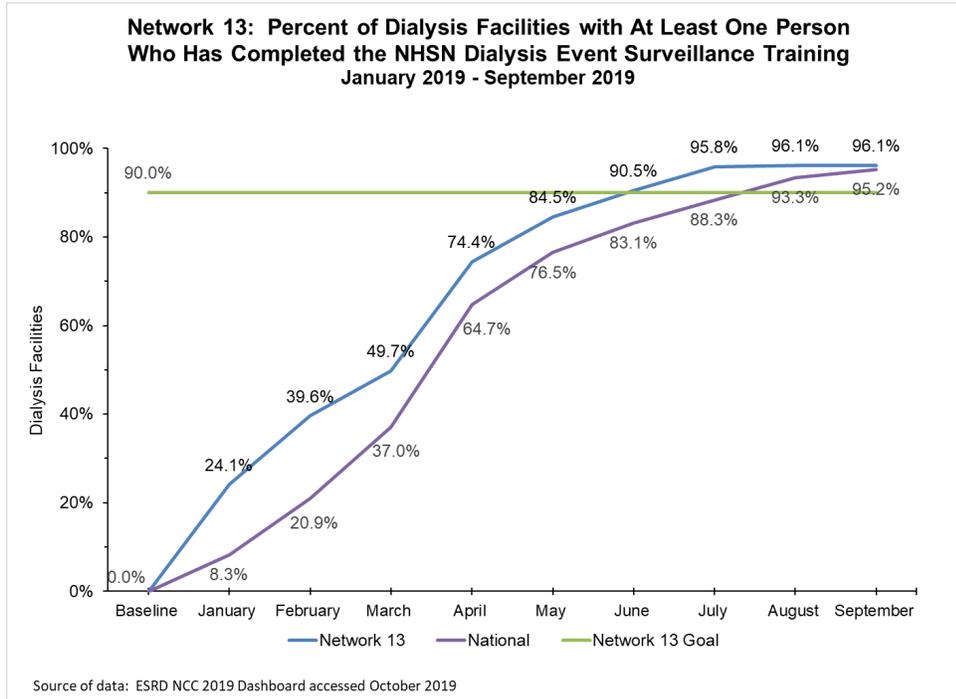
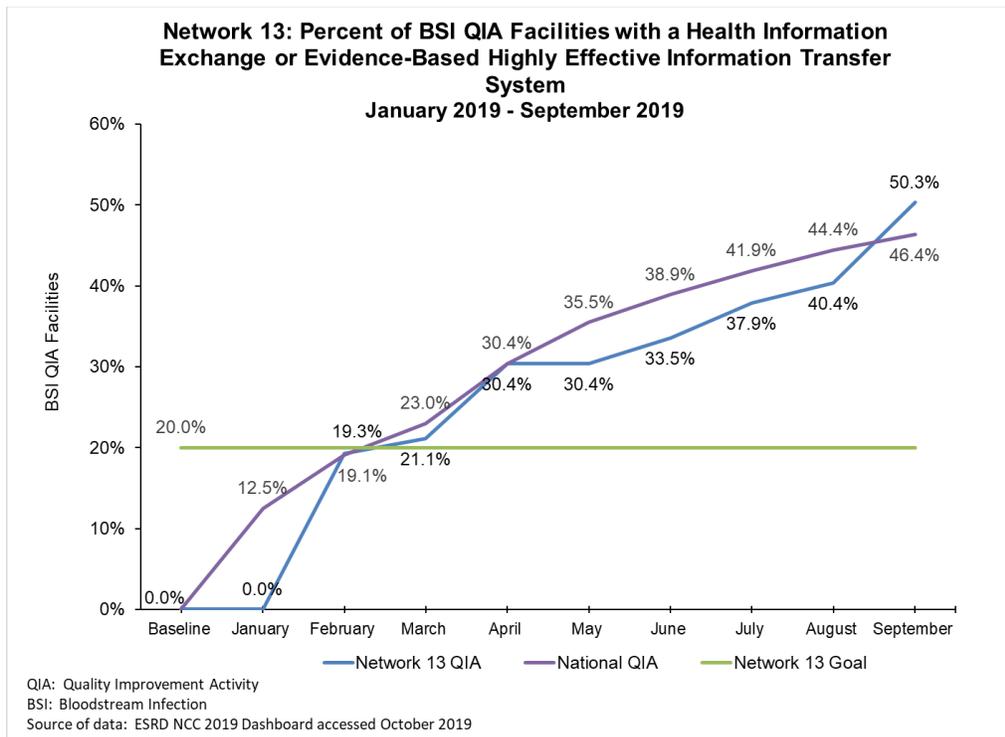


Chart N: Percent of BSI QIA Facilities With a Health Information Exchange or Evidence-Based Highly Effective Information Transfer System



Transplant Waitlist Quality Improvement Activity

In 2019, the Network continued a QIA developed/initiated in 2018 to increase the number of adult dialysis patients on a transplant waitlist. Ninety-five facilities (30.0% of the Network service area's 310 facilities), impacting 6,087 patients, were chosen to participate in the QIA.

Goals and Outcomes

The primary goal of the QIA was to demonstrate a 2.0% improvement in the rate of eligible patients placed on the waitlist for kidney transplant based on the natural trend over a five-year period, 2013–2017. The baseline waitlist rate was 3.3%. The cohort of 95 facilities had a target of 286 patients added to the transplant waiting list during the nine-month QIA timeframe.

The Network facilitated communications with the participating dialysis facilities and the nine transplant centers in the service area. Encouraging relationship building and collaboration between all stakeholders, including ESRD providers and patients, was a primary goal. While the cohort added 190 patients to the transplant waiting list, the number was 66.4% of the goal. There was consistent improvement to a final waitlist rate of 2.7%. (see Chart O)

Barriers

Barriers to achieving QIA success identified by the facilities included:

- Inconsistent communication between dialysis units and transplant centers.
- Knowledge deficits on transplant modality and referral process for both dialysis staff and patients.

Interventions

The Network addressed the barriers indicated above by implementing the following activities with the QIA facilities:

- Participation in bi-monthly NCC Transplant QIA LAN events.
- Establishment and enhancement of relationships with transplant personnel.
 - Facilitate flow of information/education for patients and staff regarding transplant using Lobby Days, educational materials, and assistance with peer mentoring.
- Designation of an NPR to support QIA activities and assist with patient and family engagement (PFE) at the facility level.
- Evaluation of reasons for patient non-interest in the transplant modality.
- Incorporation of Transplant QIA interventions into monthly facility Quality Assurance and Performance Improvement (QAPI) meetings.

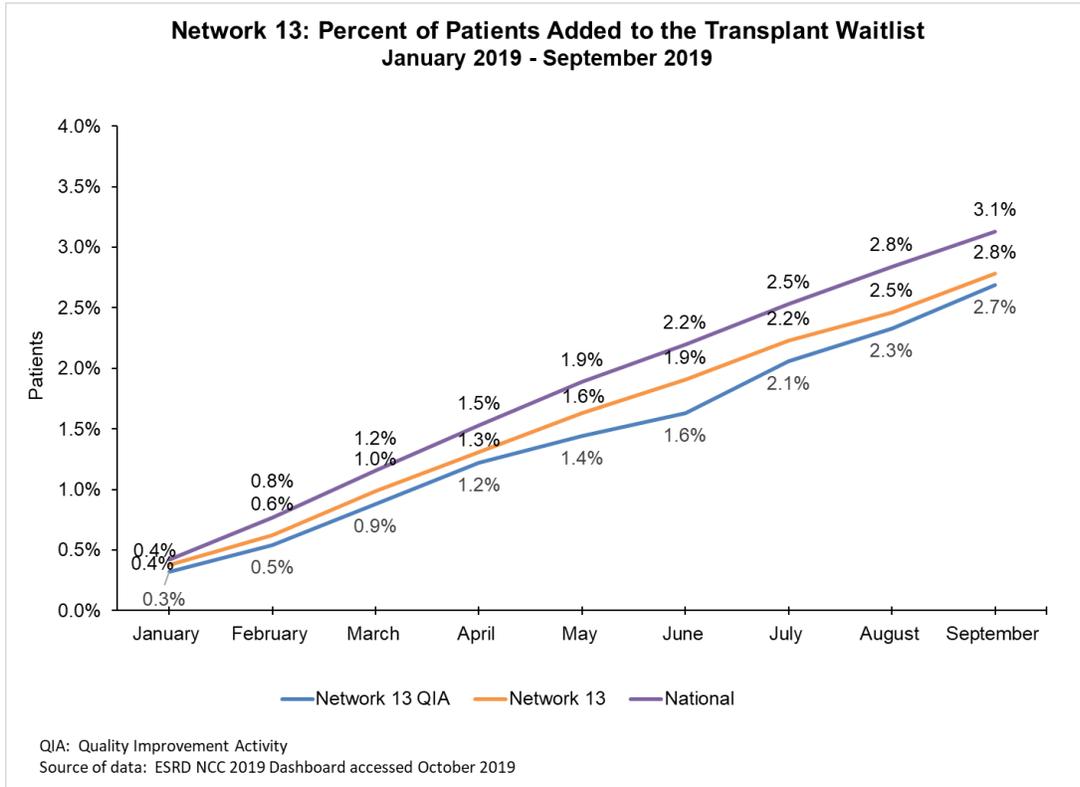
Best Practices

Best practices identified from the QIA included:

- Building relationships between transplant centers and dialysis facilities to improve communication and mitigate barriers for patients interested in transplant.
- Using a communication tool for consistent two-way communication.
- Providing transplant center staff with regularly scheduled status updates on patients who have been referred to their center; including information on health status, hospitalizations, transfusions, and change in modality.
- Receiving regularly scheduled status updates of referred patients from the transplant centers.
- Determining the reasons for patient non-interest in transplant to identify and address educational/support needs.

- Involving patients in planning for Lobby Days, support groups, and other transplant activities.
- Providing information and encouraging referral to VR for patients pursuing transplant who are not employed.
- Continuing, consistent focus on improving transplant waitlist rates.

Chart O: Percent of Patients Added to the Transplant Waitlist



Home Therapy Quality Improvement Activity

In 2019, the Network conducted a QIA to support the CMS goal of increasing the number of ESRD patients dialyzing at home by two percentage points in the natural trend of patients using a home modality and working with 30.0% of facilities in the Network service area. Ninety-five facilities, impacting 5,114 patients, were chosen to participate in the QIA. The facilities' baseline home dialysis rates ranged from zero (0.0%) to 3.7%.

Goals and Outcomes

The baseline home dialysis rate for this activity was zero percent (0.0%), with a goal to obtain a two-percentage point increase (100.0%). The goal was to increase the number of patients training on home dialysis by 396 patients by September 30, 2019. As of September 2019, the cohort group increased the number of patients on home therapies to 426 or a 107.6% increase, exceeding the goal. (see Chart P)

Barriers

The following barriers to meeting the QIA goal were identified based on facility RCA results:

- Patient choice.
 - Lack of interest.
 - Patients' socialization needs are met through in-center hemodialysis.
 - Patients want a professional to perform dialysis.
- No partner and/or lack of space for supplies.
- Patients do not feel they can do it on their own.
 - They are fearful, anxious, nervous, and hesitant.
- Education level/cognitive skills.
- Lack of family support.
- Patients don't want their families to see their treatment.
- Co-morbidities.

Interventions

Facility interventions for the QIA included:

- Orienting facilities to the project including education on the "7 Steps to Home Dialysis."
- Initiating an RCA and developing an action plan to incorporate the top two issues identified as focus areas for improvement.
- Attending and participating in the ESRD NCC Home Dialysis LAN calls, including reporting of changes the facility could make to increase home modality choice.
- Promoting home therapies with an activity, such as a Lobby Day and a *Discover Home Therapies* bulletin board.
- Conducting monthly PDSA cycle (action plan) updates via Survey Monkey®.
- Using the *7 Steps Reporting Tool* to home therapy training.
- Promoting communication between in-center dialysis facilities, home dialysis facilities, hospitals, nephrologists, and other healthcare providers to improve the rate of patients using a home dialysis modality.
- Performing a sustainability survey at the conclusion of the QIA for continued improvement and best practices.
- Providing patient education, such as NCC Home HD and PD flyers, educational puzzles on home modalities, and the *Beware of the Summer Bloom* article.

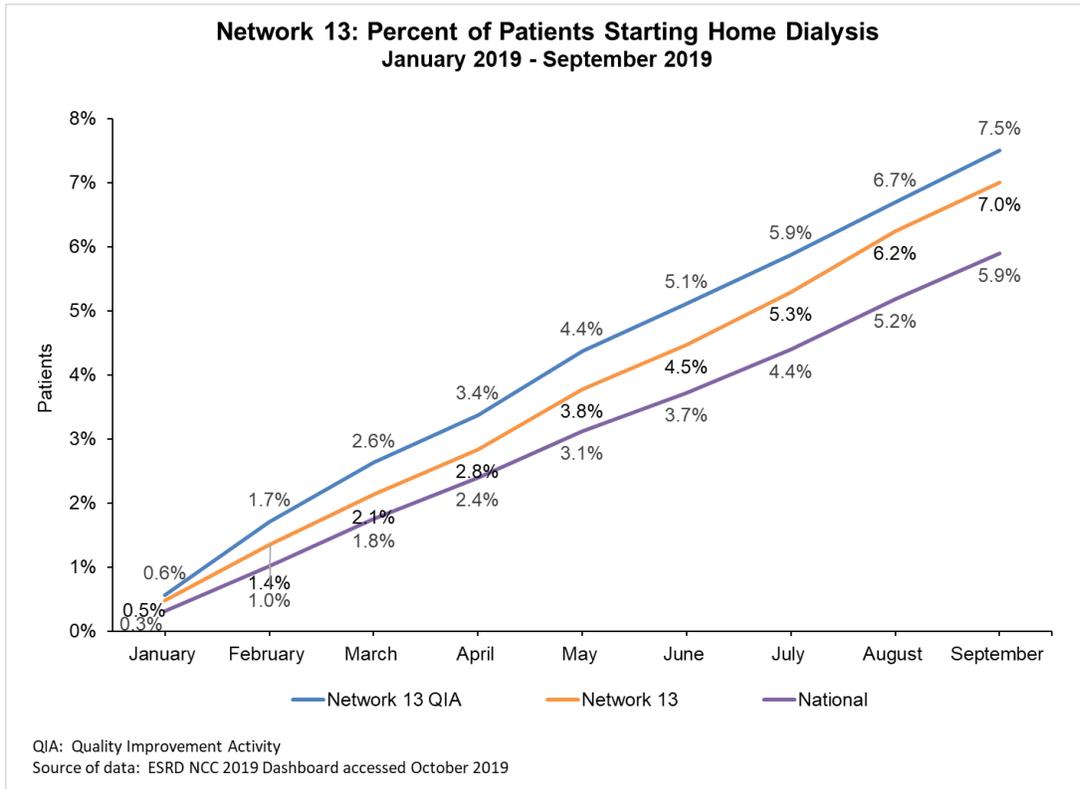
- Providing the *Patient Home Dialysis Knowledge Checklist* to patients at the baseline and completion of activity to gauge increased knowledge of home therapies.

Best Practices

Best practices identified by QIA facilities included:

- Having “do-you-feel-better” conversations.
- Encouraging nephrologists to review the list of patients interested in home dialysis and conducting a “visit” with the patients to explain the procedure.
- Keeping an open mind regarding candidates for home therapies.
- Providing education on home modalities to dispel myths.
- Using the NCC Patient Affinity Group’s *Uncovering Myths about Home: Myths vs. Reality* booklet.
- Using the Forum of ESRD Networks’ *Home Dialysis Toolkit*.
- Using the NCC *Patient Toolkit Treatment Choices*.
- Creating Home Therapies bulletin boards.
- Scheduling of Lobby Days on a quarterly basis with visual aids.
- Talking with non-adherent patients to consider transition to home.
- Using mydialysischoice.org with patients considering PD.
- Providing patient-to-patient education.
- Engaging families and patient support systems in patient education sessions.
- Inviting outside guest speakers to discuss the flexibility of home dialysis.
- Involving home dialysis patients in Lobby Days, including answering questions and providing peer support.
- Arranging a tour of home programs to give patients an idea of what it would be like to do PD.

Chart P: Percent of Patients Starting Home Dialysis



Population Health Focus Pilot Project Quality Improvement Activity

In 2019, the Network conducted a QIA on supporting gainful employment of ESRD patients. The goals were to achieve a 10.0% increase in the number of eligible patients referred to VR, and a 5.0% increase in the number of eligible patients receiving VR services. Thirty-two facilities with a total of 683 eligible patients (based on age, unemployment status—as documented in CROWNWeb) were chosen to participate in the QIA.

Goals and Outcomes

The primary goals of this QIA were to increase referrals of eligible patients to VR and increase the number of patients receiving VR services. By QIA completion in September 2019, the referral rate was 14.7%, exceeding the 10.0% goal, while the number of patients receiving services increased by 0.7%. (see Chart Q) There was a consistent increase in the number of patient referrals monthly, which should ultimately result in additional patients receiving services beyond the allotted QIA timeframe.

Barriers

The following barriers were identified based on facility RCA results:

- Unclear documentation and reporting process for referral of eligible patients to VR.
- Facility lack of knowledge of services available for patients through VR.
- Lack of motivation for patients to seek employment/VR services.
- Limited resources and job availability, especially in rural areas.

Interventions

Facility interventions for the QIA included:

- Initiating an RCA and developing an action plan to incorporate the top three issues identified as focus areas for improvement.
- Developing or reviewing the procedure for screening and referral of patients ages 18 through 54 to VR/employment networks.
- Reviewing the list of patients (ages 18 through 54) to validate current screening and update VR status in CROWNWeb.
- Contacting VR agencies to establish contact, familiarize staff with available services, and confirm referral processes.
- Developing or updating the process for referral, assistance for patients with referral, and follow-up steps with patients post-referral.
- Tracking screening and referrals for monthly reporting to Network and QAPI meetings.

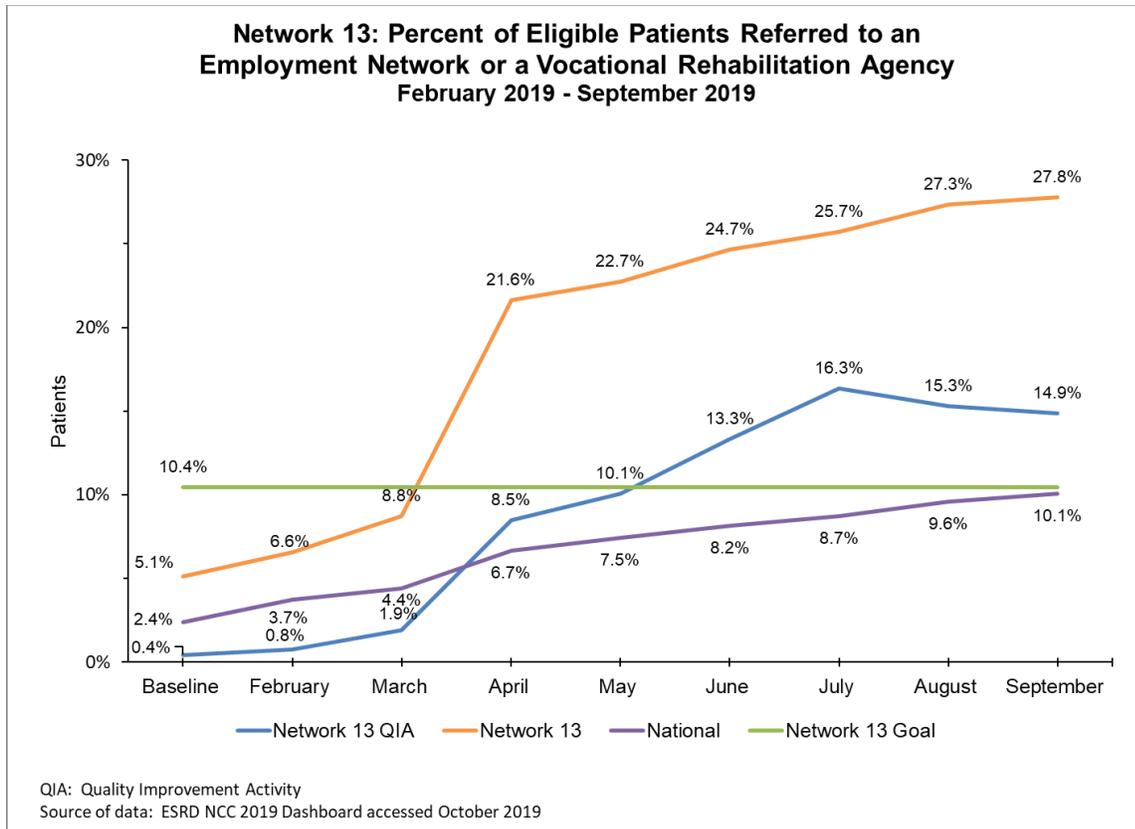
Best Practices

Best practices identified by QIA facilities included:

- Creating an atmosphere of enthusiasm regarding VR.
- Reviewing internal processes for screening and referral of eligible interested patients.
- Contacting the state and/or local VR agency to establish communications and clarify referral processes.
- Using Lobby Days with assistance from VR agency contact(s).
- Sharing patient inspirational stories:
 - Within the facility.

- On the Ticket to Work website. <https://choosework.ssa.gov/success-stories/index.html>.
- Establishing a Peer Mentoring program.
- Providing information and encouraging referral to VR for patients pursuing transplant who are not employed.

Chart Q: Percent of Eligible Patients Referred to an Employment Network or a VR Agency



ESRD NETWORK RECOMMENDATIONS

Recommendations for Sanction

The Network maintained a cooperative and collaborative partnership with ESRD providers in all activities in 2019. The Network regularly interacted with facilities regarding QIAs and projects, quality-of-care issues, patient grievances, data reporting, and the provision of technical assistance/education.

In 2019, the Network did not identify any facilities in its service area that consistently failed to cooperate with Network goals.

Recommendations to CMS For Additional Services or Facilities

There is currently no Certificate-of-Need requirement for ESRD facilities in the Network's service area. The consensus of our boards and committees is that the competitive market, by its nature, analyzes and identifies areas of need. We share available aggregate data with the SA offices and the CMS Region VI office in Dallas, as requested, for use in conjunction with other factors in their determining prioritization of certification surveys. As generally requested, the information provided to the Regional Office includes the number of patients in a given geographic area, as well as facility-related information, including services provided (modalities offered), number of stations, number of shifts, and patient capacity in the immediate geographic area (based on number of shifts and stations at other facilities).

In 2019, the Network did not make recommendations to CMS for additional facilities in its service area.

The special areas of need that the Network believes could be addressed include:

- The number of clinically challenging or disruptive patients, many of whom have been involuntarily discharged from chronic facilities and are without access to another chronic facility.
 - A “unique needs” dialysis facility could allow for higher staff-to-patient ratios and/or employ clinicians with specialized training to enable intensive, individualized services to patients with complex, clinical challenges, and/or histories of aggression, mental illness, or substance abuse.
- Dialysis patients with physical conditions (e.g., ventilator-dependent, morbidly obese, antibiotic-resistant infections, etc.), which require services that typical chronic facilities for the general dialysis population are unable to provide.

ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION

Network Emergency Preparedness

The Network made available its annual Emergency Preparedness training for dialysis and transplant providers on May 14, 2019. The training objectives were to:

- Explain emergency preparedness regulations and requirements.
- Formulate readiness steps and training for ESRD providers regarding emergency situations.
- Describe practical applications of disaster planning for the dialysis provider.

During 2019, two significant weather-related events required Network intervention and assistance for impacts affecting ESRD providers and patients.

Severe Weather/Flooding—Oklahoma

In late May, severe weather brought flooding issues throughout Oklahoma, with critical flash flooding threatening levees along the Arkansas River, protecting Tulsa, OK. The Network interacted with Tulsa-area emergency operations personnel to monitor facility operations with the potential for impacts. Interactions occurred regarding transportation issues for patients and staff, as some roads were impassible. Facilities were proactive, monitoring their water supplies and water quality, providing patient education regarding fluids/diets, and rescheduling treatments based on local conditions. No dialysis unit operations were affected long-term.

Tropical Storm (TS) Barry

TS Barry impacted Louisiana in mid July 2019. There were 142 dialysis facilities within the projected storm track, as well as further into Louisiana, that proactively prepared for weather-related events, such as heavy rain and tropical storm conditions. Facilities in the immediate TS path in south Louisiana opened early where possible, allowing them to close early prior to the storm's arrival. Facilities applied their emergency preparedness plans for both patients and staff. The Network interacted and facilitated activities with the Louisiana emergency operations center for the six-day duration of the event.

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.

Acronym	Definition
BSI	Blood Stream Infection
CDC	Centers for Disease Control and Prevention
CDHE	Colorado Department of Health and Environment
CMS	Centers for Medicare & Medicaid Services
ESRD	End Stage Renal Disease
FDA	Food and Drug Administration
HAIs	Healthcare Associated Infections
HHS	Health and Human Services
HSAG	Health Services Advisory Group
HIE	Health Information Exchange
KCER	Kidney Community Emergency Response
LAN	Learning and Action Network
LTC	Long-Term Catheter
LDOs	Large Dialysis Organizations
PDSA	Plan Do Study Act: A cycle of improvement
PHFPQ	Population Health-Focused Pilot
PSME	Patient Subject Matter Expert
QAPI	Quality Assurance and Performance Improvement
QIA	Quality Improvement Activity
RCA	Root Cause Analysis
SME	Subject Matter Expert
UNOS	United Network for Organ Sharing