

# ESRD NETWORK 2018 ANNUAL REPORT

Health Services  
Advisory Group  
(HSAG): End Stage  
Renal Disease (ESRD)  
Network 17

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## ESRD DEMOGRAPHIC DATA

### ESRD Network 17

As part of the HSAG team, Network 17 works with patients and providers in the northern portion of California, Hawaii, Saipan (U.S. Commonwealth of the Northern Marianas Islands), and the U.S. Territories of Guam and American Samoa to improve the quality of care and quality of life for ESRD patients. HSAG has held the Network 17 contract since 2015.

### Geography and General Population

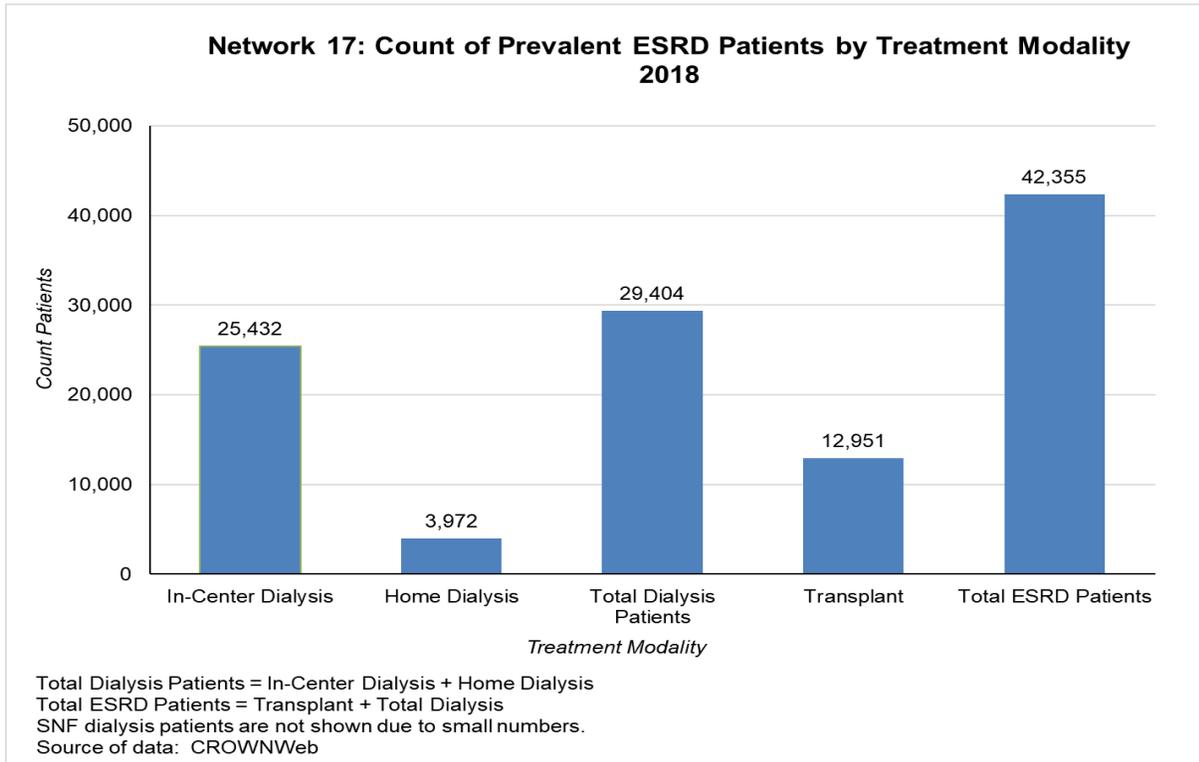
Network 17 spans approximately 10,000 square miles, which includes crossing the International Date Line to reach Guam and Saipan and passing south of the equator to American Samoa. Network 17's region includes:

- Northern California:
  - Covers the 45 most northern counties in California, starting in Fresno County and ending at the Oregon border.
  - Constitutes about one-third of the state's population and about 60% of the land area.
- Hawaiian Islands:
  - Include 137 islands, the largest of which is Hawaii, followed by Maui and Oahu.
  - Have a very diverse population comprised of persons identifying themselves as Native Hawaiian, Asian, Caucasian, and Pacific Islanders.
- American Samoa:
  - Has been a territory of the U. S. since 1900.
  - Has approximately 95% its population living on the largest island, Tutuila.
- Guam:
  - Is located in the Western Pacific Ocean.
  - Is part of the Mariana Islands.
  - Crosses the International Dateline and is approximately 19 hours by air from San Francisco.
- Saipan:
  - Crosses the International Dateline and is approximately 19 hours by air from San Francisco.
  - Has a population that includes Chamorro and other Micronesians.

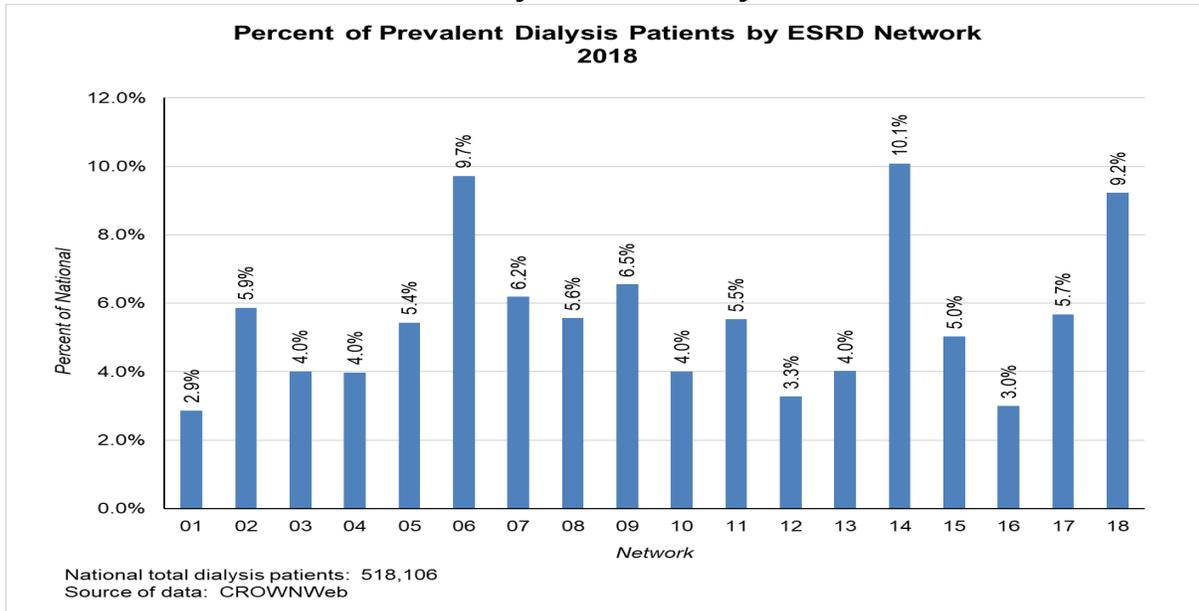
### ESRD Population

As of December 31, 2018, there were 29,404 dialysis patients and 12,951 transplant patients, for a total of 42,355 patients with ESRD in the Network 17 service area. (See Chart A) The number of incident patients increased by 367, for a total of 6,770 individuals newly diagnosed with ESRD in 2018. As of December 31, 2018, Network 17 comprised 5.7% of the total national dialysis patient population. (See Chart B)

**Chart A: Network 17: Count of Prevalent ESRD Patients by Treatment Modality 2018**



**Chart B: Percent of Prevalent Dialysis Patients by ESRD Network 2018**



## Race and Ethnicity <sup>1</sup>

As of December 31, 2018, 51.3% of prevalent dialysis patients in the Network 17 service area were characterized as White and 23.3% as Asian. The third largest race reported by patients was African American (12.4%), followed by Native Hawaiian or Other Pacific Islander (11.7%). Ethnically, the majority of prevalent patients in the Network 17 service area (75.4%) were characterized as Not Hispanic or Latino as of December 31, 2018.

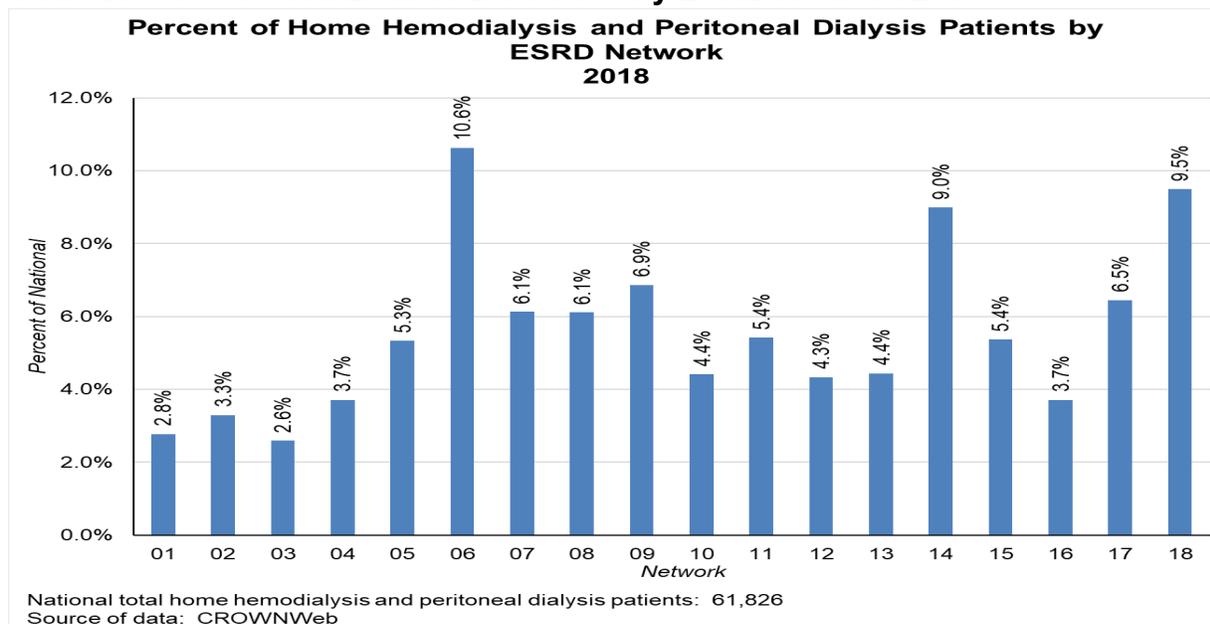
## Gender and Age

Fifty-eight percent of prevalent ESRD patients in the Network 17 service area were male, 42.0% were female, and 68.2% were between the age of 45 and 74 as of December 31, 2018.

## Dialysis Treatment Options

As of December 31, 2018, 86.4% of dialysis patients in Network 17 were receiving in-center hemodialysis (ICHD) treatments and 13.5% were using a home dialysis modality, including continuous-cycling peritoneal dialysis (CCPD), continuous-ambulatory peritoneal dialysis (CAPD), or home hemodialysis (HHD). (See Chart A) Nationally, the Network comprised 6.5% of all CCPD, CAPD and HHD patients. (See Chart C)

**Chart C: Percent of HHD and PD Patients by ESRD Network 2018**

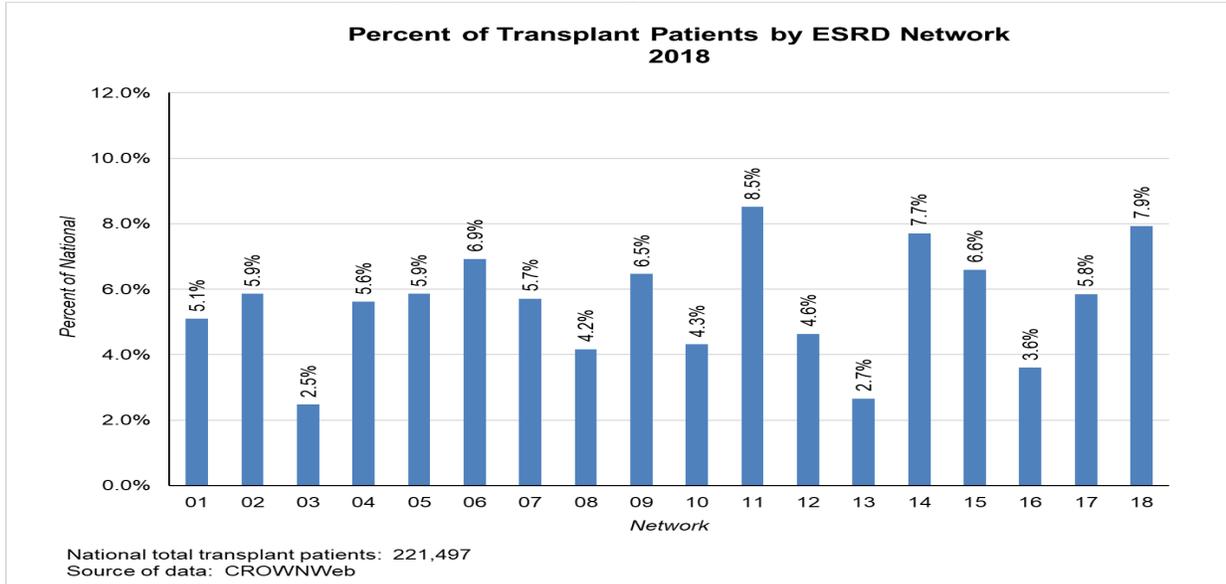


<sup>1</sup> Data on "ethnicity" and "race" should be interpreted with caution because of the inherent instability of race/ethnicity data.

## Transplant

During 2018, 1,113 kidney transplants were completed by the six transplant centers in the Network 17 service area. As of December 31, 2018, there were 221,497 transplant patients nationally, of which 5.8% were in Network 17. (See Chart D)

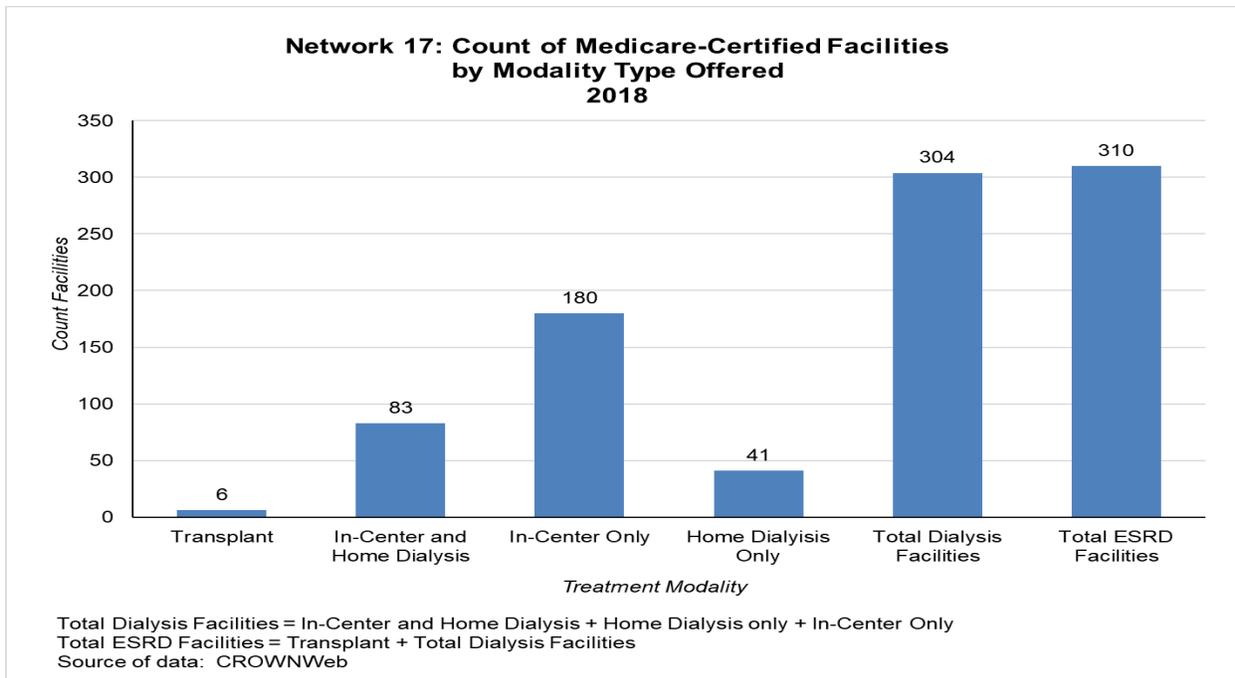
**Chart D: Percent of Transplant Patients by ESRD Network 2018**



## ESRD Facilities

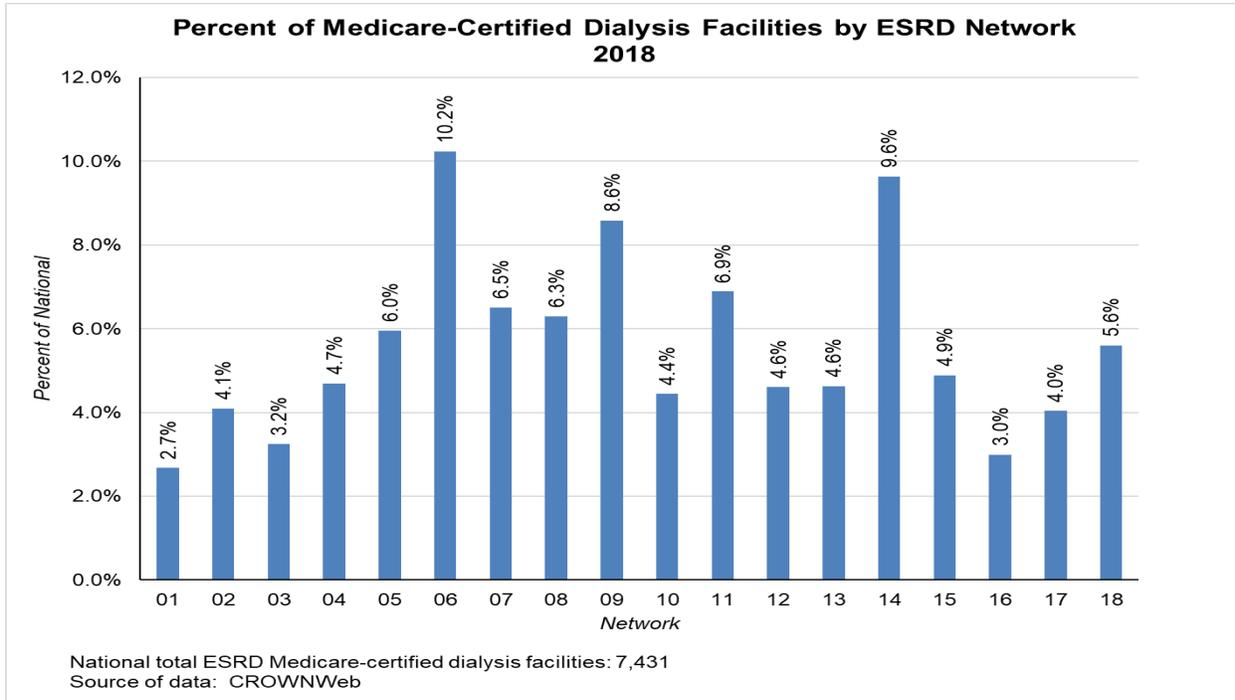
As of December 2018, Network 17's service area included a total of 310 ESRD facilities, including 304 dialysis facilities and six transplant facilities. (See Chart E)

**Chart E: Network 17 Count of Medicare-Certified Facilities by Modality Type Offered 2018**

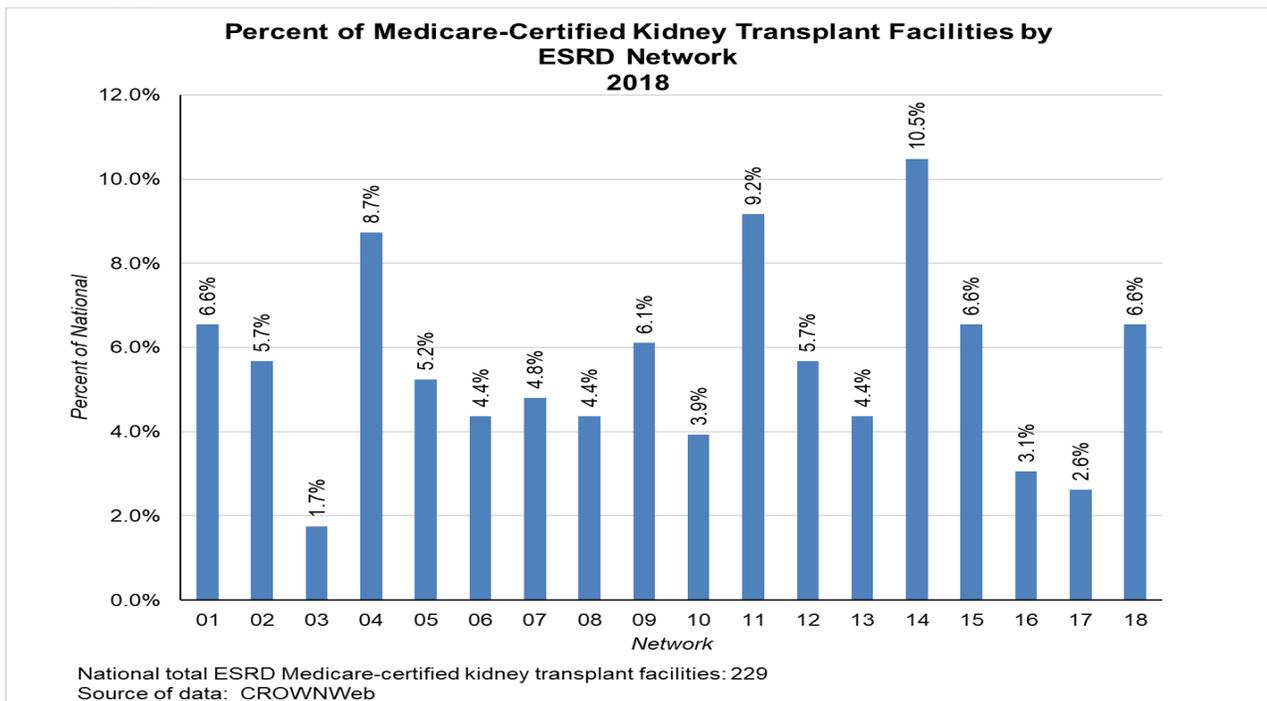


Nationally, Network 17 comprised 4.0% of all dialysis facilities (See Chart F) and 2.6% of all transplant facilities (See Chart G)

**Chart F: Percent of Medicare-Certified Dialysis Facilities by ESRD Network 2018**

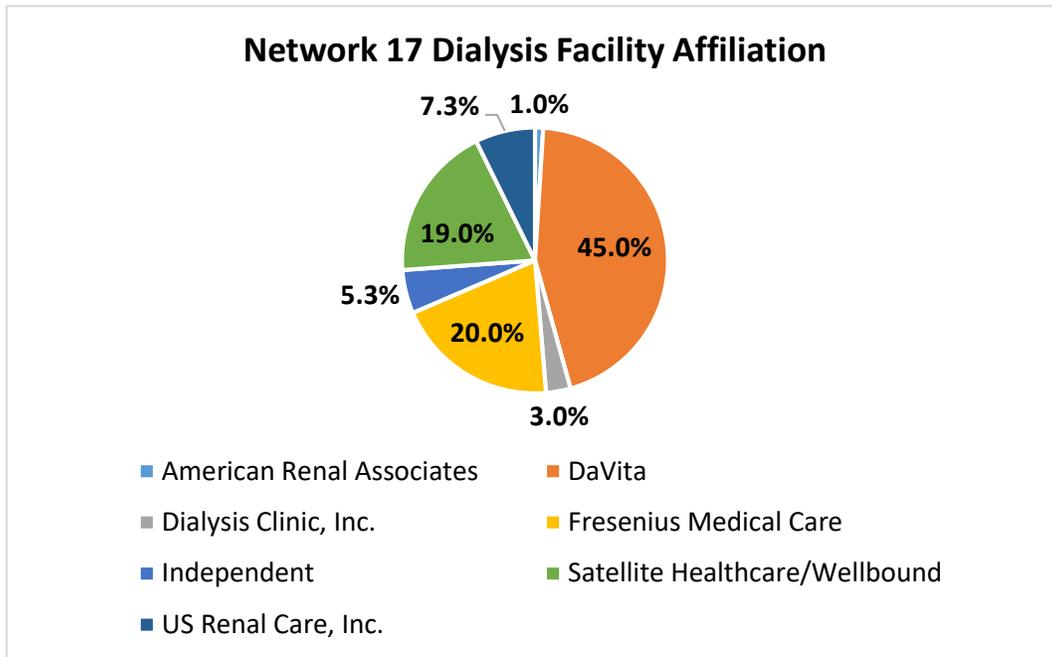


**Chart G: Percent of Medicare-Certified Kidney Transplant Facilities by ESRD Network 2018**



## Dialysis Facility Affiliation

Sixty-eight percent of the 304 dialysis facilities in the Network 17 service area were owned and/or operated by the three large dialysis organizations (LDOs): DaVita Kidney Care (DVA), Fresenius Medical Care (FMC), and Dialysis Clinic Incorporated (DCI) at the end of 2018; 45.0% were affiliated with DVA, 20.0% with FMC, and 3.0% with DCI.





## ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA

### Grievances

The Network responds to grievances filed by or on behalf of ESRD patients in its service area. Grievances may focus on staff issues, quality of care issues, or environmental issues. Grievances are addressed through Immediate Advocacy, where the Network contacts the facility to resolve the issue within seven business days, through a General Grievance, which can take 60 days to resolve, or a Clinical Area of Concern, where records are requested and a grievant receives a final outcome letter. According to Chart H below, during 2018, 10% of contacts to the Network were for grievances, including 8% for Immediate Advocacy, 1% for Clinical Areas of Concern, and 1% for General Grievance.

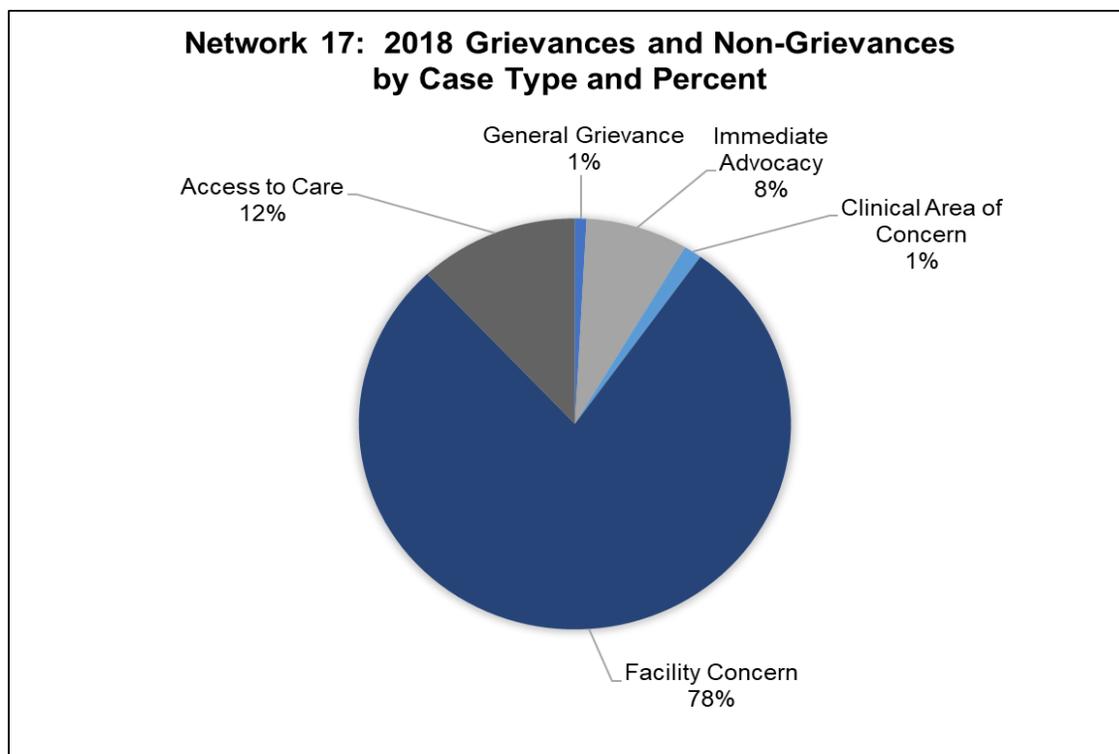
### Facility Concerns

In addition to grievances, the Network also responded to facility concerns, which were 78% of all contacts to the Network in 2018. Facility Concerns include contacts received from ESRD providers and facilities related to managing difficult patient situations, requests for technical assistance, and other concerns.

### Access to Care Issues

The Network works with facilities and advocates for patients to avert potential Access to Care issues whenever possible. Access to Care concerns include patients at-risk for Involuntary Discharge (IVD) or Involuntary Transfer (IVT), and patients who have not been able to permanently establish themselves with an outpatient dialysis facility. During 2018, Access to Care issues accounted for 40% of contacts to the Network.

**Chart H: Network 17: 2018 Grievances and Non-Grievances by Case Type and Percent**



Source of data: Patient Contact Utility (PCU)



# ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY (QIA) DATA

## Long-Term Catheter (LTC) QIA

In 2018, the Network conducted a QIA to reduce LTCs in facilities with rates above 15%. The objectives of the QIA were to create a foundation of sustainable facility processes for catheter reduction and to promote timely and accurate vascular access reporting in CROWNWeb.

### Goals and Outcomes

Using August 2017 CROWNWeb data for the baseline, the Network identified 11 facilities with rates above 15% that had an aggregate baseline LTC rate of 17.9%. The goal was to achieve a two-percentage point reduction among the identified subset of facilities, or to reach 15.9%, by July 2018. The 11 facilities reduced their LTC rate to 15%, which exceeded the goal of 15.9%. (See Chart I)

### Barriers

Barriers to reducing LTCs reported by facilities included:

- Patients refusing to have a permanent access placement timely.
- Patients with multiple accesses that were not able to work.
- Lack of adequate surgeon availability to place permanent accesses or conduct timely access interventions.

### Interventions

Interventions for the QIA included:

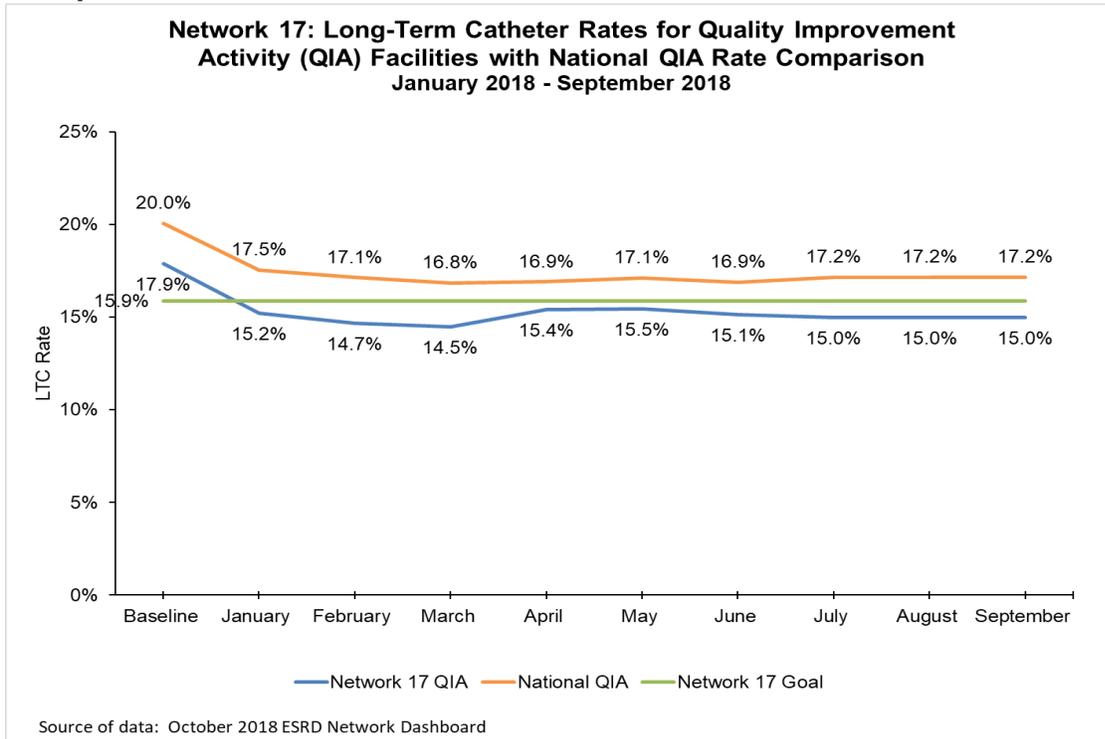
- Distributing patient education tools, including tools that explained the:
  - Advantages of a permanent access versus a catheter.
  - Importance of hand hygiene and proper access care.
- Distributing resources to identify and maintain a facility Vascular Access (VA) manager.
- Encouraging use of a tracker for monitoring patient appointments.
- Collecting and trending facility data to conduct rapid cycle improvement.

### Best Practices

Best practices identified by QIA facilities included:

- Developing a process to provide VA education to patients upon initiation of dialysis.
- Holding a celebration in the facility for each new permanent access placed.
- Conducting a meeting with the local surgeon(s) office(s) to address timely evaluation and placement of permanent accesses.

**Chart I: Network 17 LTC Rates for QIA Facilities with National QIA Rate Comparison**



## Bloodstream Infection (BSI) QIA

In 2018, the Network conducted a QIA to reduce dialysis event rates, specifically BSIs, that 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 BSI Prevention Program. The 123 QIA facilities were further divided into the following cohorts:

- BSI only facilities: 82, impacting approximately 8,400 patients.
  - Fifty facilities from this cohort were included in the 20% reduction focus group.
- LTC and BSI facilities: 11, impacting approximately 1,017 patients.
- BSI monitoring facilities: 30, impacting approximately 2,261 patients.

While 123 facilities were included in the QIA, the measurement for Network success was based on the 20% of facilities in the cohort (n=50) with the highest BSI rates.

## Goals and Outcomes

The baseline BSI rate for the cohort facilities was 1.115%. 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 achieve at least a 20% reduction in the pooled mean rate of BSIs from January–June 2018. The aggregate BSI rate decreased from 1.115 to 0.620 by the conclusion of the QIA. (See Chart B) Additionally, by September 30, 2018, 100% of all dialysis facilities reporting in NHSN had completed the *NHSN Dialysis Event Surveillance training*, and 35.8% of the facilities included in the group of facilities with the highest BSI rates, gained access to a Health Information Exchange (HIE). (See Charts C and D)

## Barriers

Facilities reported the following barriers to further reducing BSIs at their facilities:

- Lack of staff focus on infection prevention techniques and event reporting.
- Poor patient compliance with hand washing and catheter care.

## Interventions

Interventions implemented during the QIA included:

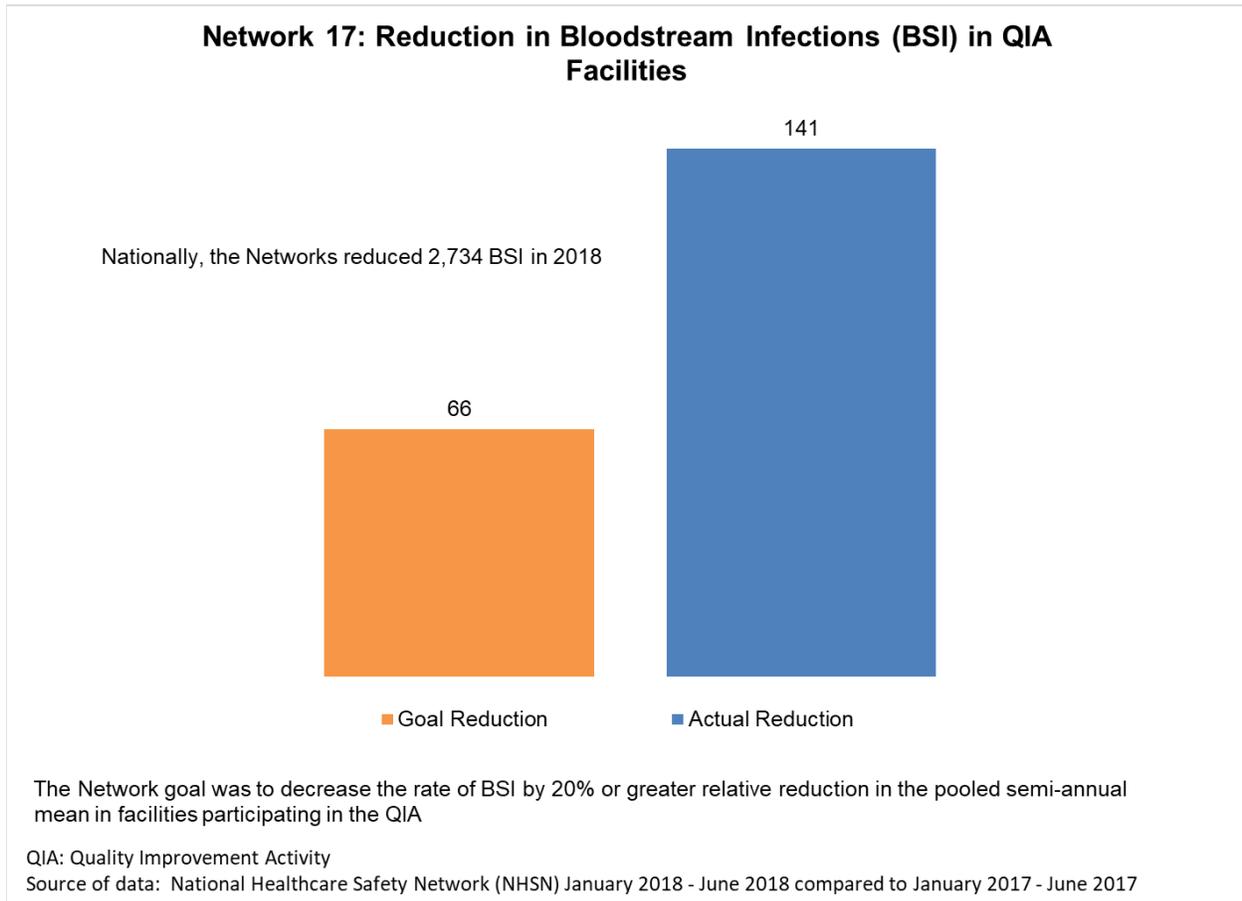
- Directing facilities to have staff complete the following training courses:
  - *Infection Prevention in the Dialysis Setting*.
  - *NHSN Dialysis Event Surveillance*.
- Distributing patient education related to hand hygiene.
- Disseminating the interactive patient learning module, *Test your Hand Hygiene Knowledge*.
- Collecting and trending facility data to conduct rapid cycle improvement.
- Providing education on the 9 CD core interventions.
- Having facilities complete CDC BSI prevention audit tools for staff.
- Posting the CDC's *Days Since Last BSI* poster.
- Additional education and best practices gained through the ESRD National Coordinating Center's (NCC's) BSI QIA Learning and Action Network (LAN).
- Encouraging facilities to work toward obtaining access to a HIE in their area.

## Best Practices

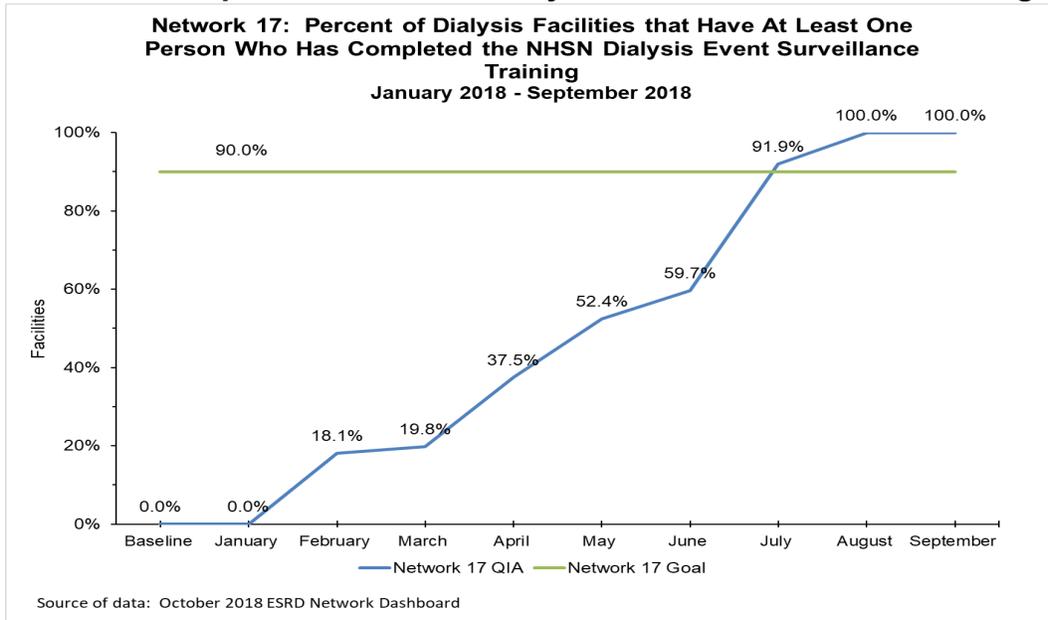
Best practices identified by QIA facilities included:

- Developing a process to provide VA education to patients upon initiation of dialysis.
- Holding a celebration in the facility for each hurdle overcome during the permanent access placement process.
- Ongoing completion of the CDC infection control audits and including patients in the monthly hand hygiene audits.
- Using *Clear Guard* Antimicrobial Barrier Caps.

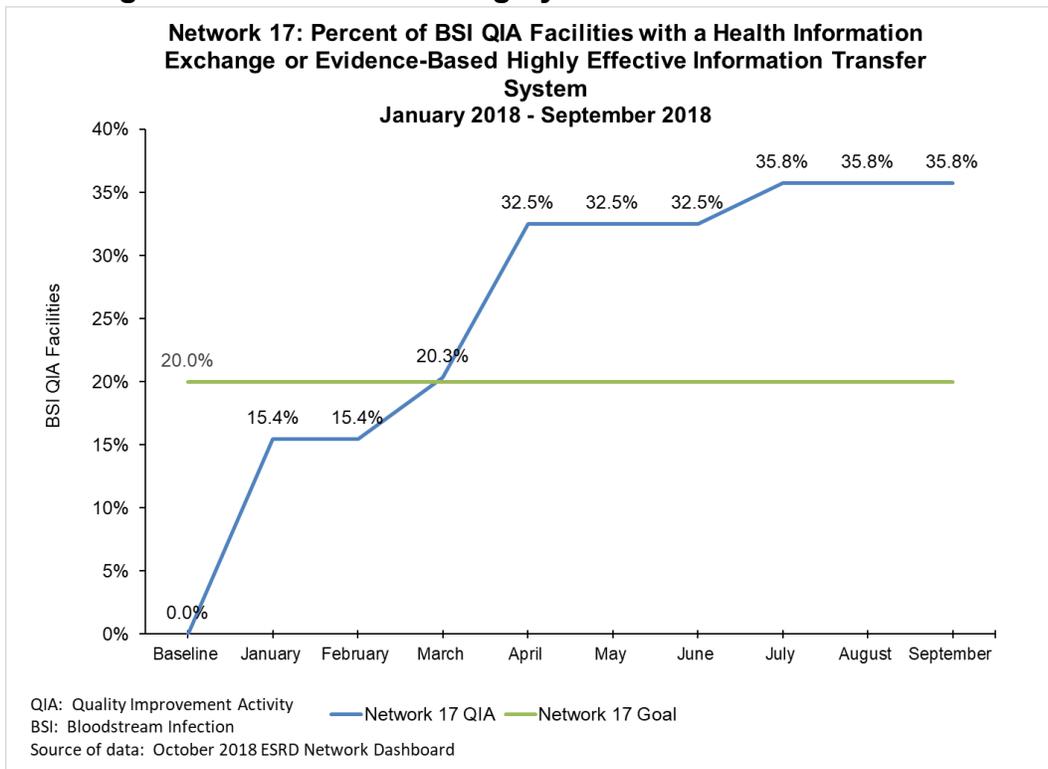
## Chart J: Network 17 Reduction in BSIs in QIA Facilities



**Chart K: Network 17 Percent of Dialysis Facilities That Have At Least One Person Who Has Completed The NHSN Dialysis Event Surveillance Training**



**Chart L: Network 17 Percent of BSI QIA Facilities with a Health Information Exchange or Evidence-Based Highly Effective Information Transfer System**



## Transplant Waitlist QIA

In 2018, the Network conducted a QIA to support the CMS goal of increasing the rates of dialysis patients on a transplant waitlist by 10 percentage points over the baseline for a targeted group of dialysis facilities.

### Goals and Outcomes

The Network identified 87 dialysis facilities for inclusion in the QIA, impacting approximately 7,600 hemodialysis patients. The baseline rate was 19.9%, and the final measure rate, as of September 2018, was 22.2%. (See Chart M)

### Barriers

Barriers to meeting the QIA goals included:

- Patient refusals.
- Lack of a structured communication process between the dialysis facilities and transplant centers.
- Patients being unable to meet the criteria for transplant referral or being unable to complete the work-up.

### Interventions

The Network addressed each of the barriers indicated above with the following interventions:

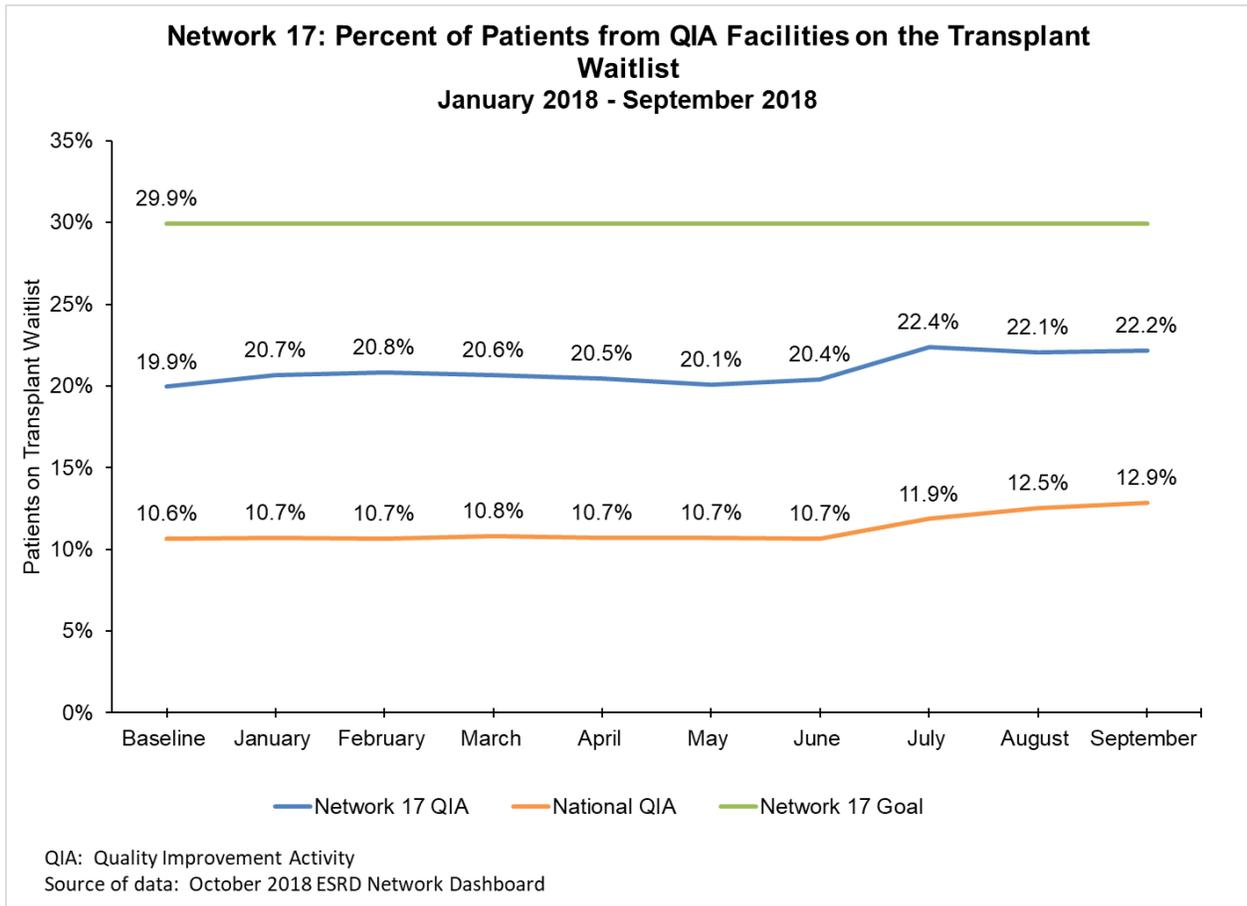
- To explore the large number of patient refusals, the Network created a resource that the facilities could use to ask patients why they were not interested in pursuing a transplant.
  - The network collected the patients' responses from facilities and the results were reviewed and discussed with Network Patient Subject Matter Experts (PSMEs). Based on feedback from the PSMEs, the Network began the development of two interventions:
    - A transplant referral guide.
    - Patient testimonials that address the risks vs. the rewards of receiving a transplant.
- The Network encouraged the QIA facilities to build a workable, structured communication process with the transplant centers with the goal of successfully exchanging information to expedite the referral process.
  - To achieve this, the Network shared best practices identified by QIA facilities and the ESRD NCC Transplant LAN.
- To ensure proper tracking and documentation of each patient's movement through the steps to transplant wait listing, the Network created and disseminated a Seven Steps to Transplant tracker for use by QIA facilities.
  - The tracker could also be used for ease in completing monthly QIA reporting to the Network.

### Best Practices

Best Practices identified from the QIA include:

- Conducting educational Lobby Days to create patient interest in transplant.
- Building better communication processes with transplant centers for exchanging information.
- Referring patients to more than one transplant center if they meet the criteria.

**Chart M: Network 17 Percent of Patients from QIA Facilities on the Transplant Waitlist**



## Home Therapy QIA

In 2018, the Network conducted a QIA to support the CMS goal of increasing the number of ESRD patients dialyzing at home by 10 percentage points over the baseline for a target group of dialysis facilities.

### Goals and Outcomes

The Network identified 74 dialysis facilities (30%) for inclusion in the QIA, impacting approximately 8,195 patients. The baseline rate was 0.4%, and the final measure, as of September 2018, was 3.3%. (See Chart N)

### Barriers

Barriers to meeting QIA goals included a lack of:

- A formal tracking process for timely follow-up with patients in need of education and who had been referred.
- A home program to partner and collaborate with for the QIA.
- Patient and/or caregiver interest in home dialysis.

### Interventions

The following interventions were implemented to address barriers over the course of the QIA:

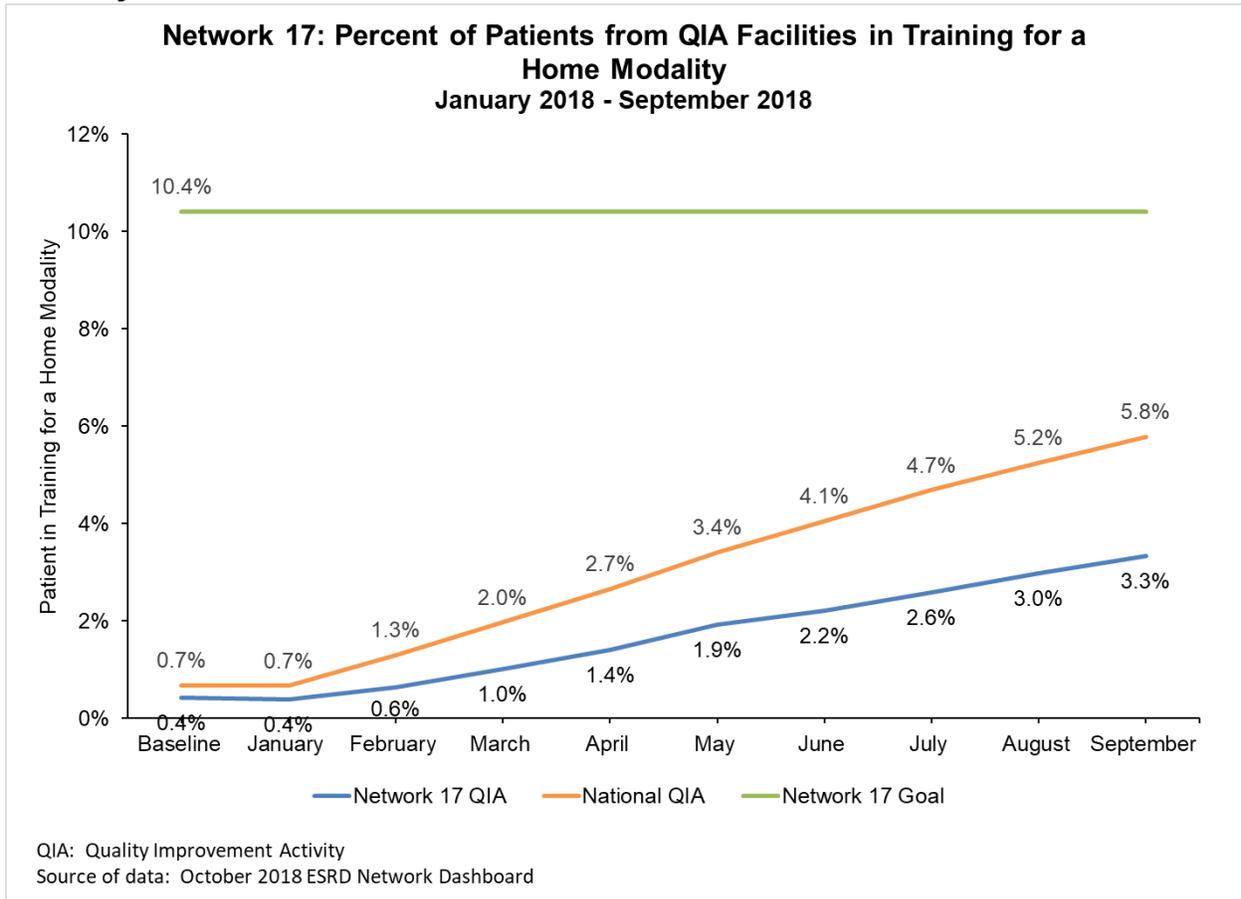
- Using a home dialysis patient tracker to monitor patients through the steps to home dialysis.
- Collaborating with a home dialysis program for patient and staff education.
- Educating new and existing in-center patients regarding home dialysis.
- Hosting a home dialysis Lobby Day with assistance from a home program, including an existing home patient and/or caregiver.
- Collecting monthly reports from QIA facilities to show the progression of patients from referral to training and implementation of QIA activities.

### Best Practices

Best practices identified through the QIA include:

- Using the home dialysis tracking tool created by the Network or an internal tracking tool.
- Continuing ongoing communication with a partnering home program for timely patient follow-up.
- Administering the Match-D assessment tool.
- Educating patients at their level of readiness using the following materials:
  - *Could Home Dialysis be a Choice for Me*
  - *My Dialysis, My choice*
- Conducting a Lobby Day using the Network's *Tips for Engaging Patients When Hosting a Lobby Day* resource.
- Developing support from the facility medical director and other nephrologists to transition patients through the seven steps to home dialysis training.

**Chart N: Network 17 Percent of Patients from QIA facilities in Training for a Home Modality**



## Population Health Focused Pilot Project QIA: Positively Impact the Quality of Life of the ESRD Patient with a Focus on Pain Management

In 2018, Network 17 conducted a QIA that focused on improving pain management in 10% of the dialysis facilities in the Network service area (n=28).

### Goals and Outcomes

The primary goal of the QIA was to achieve a 10% improvement in the completion of pain assessments in the Network service area and achieve a 100% zero rate of “no pain assessment completed, and no reason given” in CROWNWeb by the end of September 2018. The baseline rate for “no pain assessment and no reason given” for the 28 facilities was 54.8% based on October 2016–June 2017 CROWNWeb data. By QIA completion, the pain assessment rate for ‘no pain assessment and no reason given,’ decreased to 0.1%, representing a reduction of 54.7%. (See Chart O) The Network was also able to decrease the number of patients with a positive pain assessment and no follow-up plan from 0.7% to 0.0% by the end of the QIA. (See Chart P)

A secondary goal of the QIA was to eliminate the disparity between the disparate population (race other than White), as compared to a non-disparate population (White), when measuring pain assessments documented as “no pain assessment completed, and no reason given.” The baseline disparity rate among the 28 facilities was 6.1% based on October 2016–June 2017 CROWNWeb data. By the close of the QIA, the Network reduced the disparate rate from 6.1% to 0.1%, representing a 6.0% reduction. (See Chart Q)

### Barriers

Root cause analysis (RCA) on 28 facilities exhibited the following causes for poor performance on the completion of pain assessments:

- Lack of facility leadership knowledge and inadequate staff training regarding purpose and method for completing pain assessments and follow-up plans.
- Lack of facility processes to track, monitor, and ensure pain assessments and follow-up plans are completed and documented.
- Lack of streamlined process for reporting of pain assessments in CROWNWeb, resulting in missed or incomplete pain assessments and lack of reporting per required timeframes.
- CROWNWeb batching errors.

### Interventions

The QIA interventions included:

- Using a tracking and monitoring tool to ensure pain assessments are completed on all eligible patients.
- Collecting monthly feedback regarding pain assessments on patients reporting, including the type of pain and interventions to address symptoms of pain.
- Educating patients on non-medication strategies for pain management using a Network PSME-developed resource titled, [\*Keep Comfortable on Dialysis\*](#).
- Referring patients to a primary care provider (PCP) or specialist for pain management.
- Documenting appointments related to pain management in the electronic medical record.
- Educating staff about conducting pain assessments, to include:

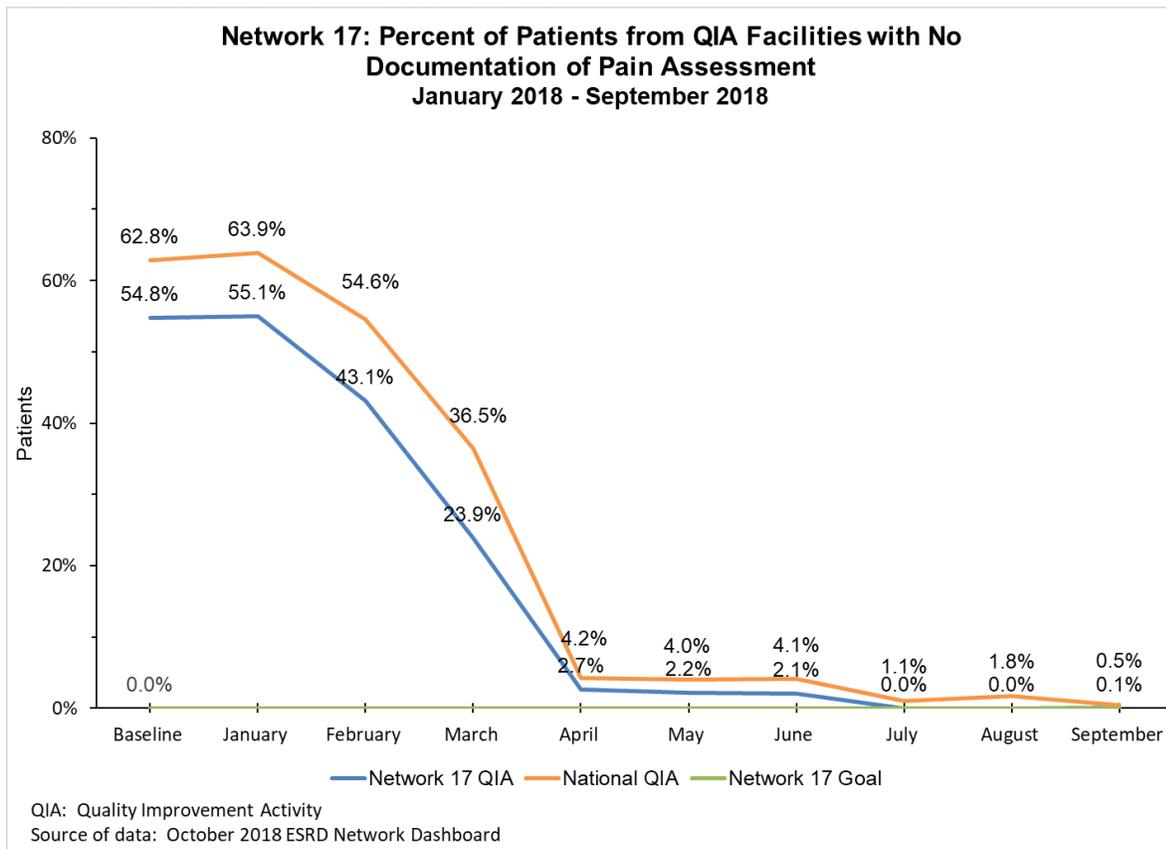
- Facility policy and procedure for conducting pain assessments.
  - Centers for Medicare & Medicaid Services (CMS) Quality Incentive Program (QIP) pain assessment reporting requirements.
  - Chronic vs. acute pain.
  - Non-medication strategies for pain management.
- Instructing facilities to identify the timing of their batch and the template used to capture the data, to ensure that the most current pain assessment data was documented and batched into CROWNWeb.

## Best Practices

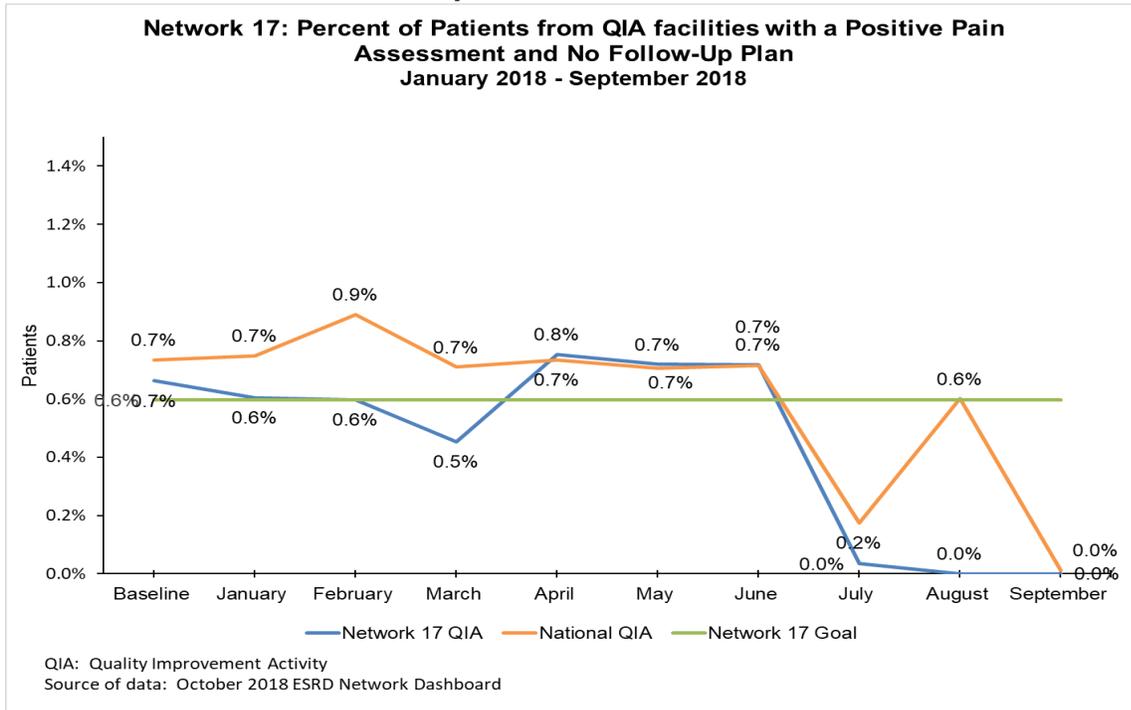
Best practices identified by QIA facilities included:

- Ongoing monitoring and tracking of pain assessment follow-up plans for patients reporting pain.
- Educating staff and patients about non-pharmacological interventions for pain.
- Obtaining CROWNWeb access for a least one nurse.
- Referring patients to a PCP or specialty doctor for pain management.
- Conducting medication reviews to verify medication prescriptions for pain management.

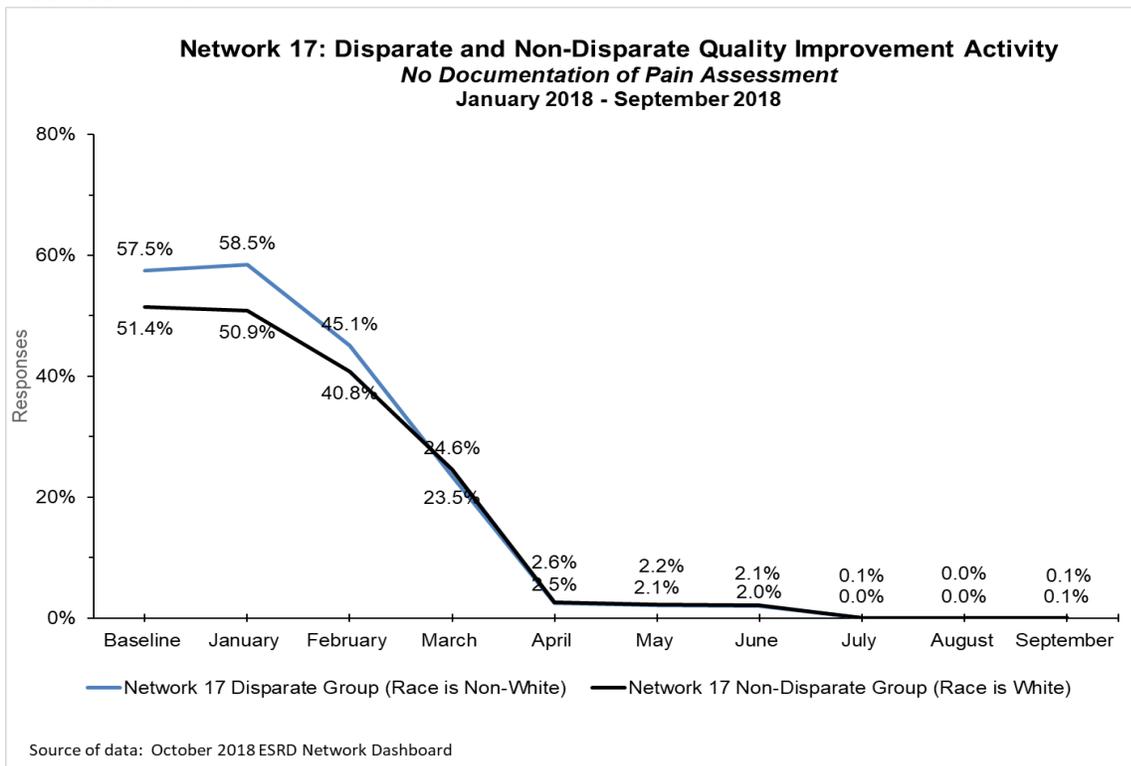
**Chart O: Network 17 Percent of Patients from QIA Facilities with No Documentation of Pain Assessment**

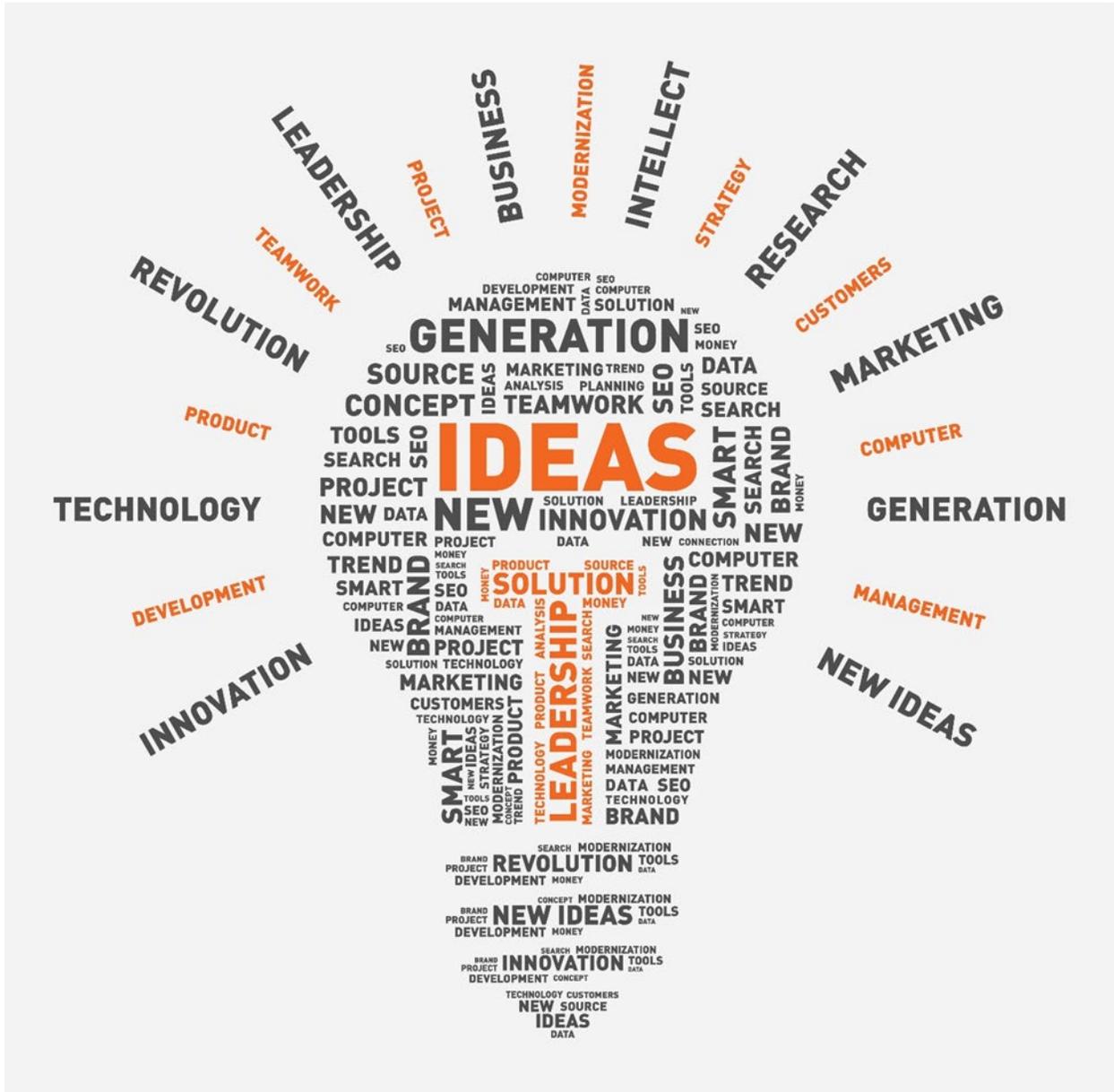


**Chart P: Network 17 Percent of Patients from QIA facilities with a Positive Pain Assessment and No Follow-Up Plan**



**Chart Q: Network 17 Disparate and Non-Disparate QIA No Documentation of Pain Assessment**





## **ESRD NETWORK RECOMMENDATIONS**

### **Recommendations for Sanction**

Section 1881(c) of the Social Security Act states that the ESRD Network can recommend to Centers for Medicare & Medicaid Services (CMS) the imposition of a sanction when an ESRD provider is not cooperating in achieving Network goals. The Federal Regulations that implement this statute are found in 42 CFR §405.2181. The Network strived to maintain a cooperative and collaborative partnership with ESRD providers in all activities in 2018. The Network regularly interacted with facilities regarding QIAs and projects, patient grievances, data reporting, and the provision of technical assistance and education.

In 2018, the Network did not identify any facilities that warranted a recommendation for sanctions.

### **Recommendations to CMS for Additional Services or Facilities**

During 2018, the Network did not identify a need for additional services or facilities in the Network 17 service area.



## **ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION**

ESRD Network 17 is tasked with providing support to dialysis facilities related to emergency preparedness, planning, and response. The Network conducts a risk assessment and submits an emergency plan annually to CMS. The Network works closely with the Kidney Community Emergency Response (KCER) Coalition and other stakeholders to ensure patients have access to dialysis before and after an emergency event. When a storm is approaching, the Network issues weather preparedness alerts to facilities in the affected areas. The Network collects information from facilities related to planned closures prior to an event and then monitors and tracks the open and closed status of facilities and the location of patients during the response. Support and resources regarding disaster preparedness and response are also provided to patients and staff who contact the Network's toll-free helpline.

Below are the emergency events Network 17 responded to during 2018.

### **February 2018:**

- **Tropical Cyclone Gita**

Tropical Cyclone Gita formed in the South Pacific Ocean on February 9, 2018. One dialysis facility, located in American Samoa, closed for one day after the storm passed due to power and water outages. The facility re-opened on Sunday, February 11, 2019, and all patients were accounted for. The Network provided support and remained in contact with facility staff and provided status reporting to KCER and CMS related to the incident.

### **March 2018:**

- **Flooding**

On March 22, 2018, the Network monitored a flash flood warning due to heavy rains and possible dam failure in Tuolumne County, CA. Based on information obtained from the Network's contacts within the facilities, none were affected, but two patients had to seek temporary emergency shelter, and some roads were closed briefly.

### **April 2018:**

- **Kauai, Hawaii, Flooding and Mudslides**

The Network provided open and closed status updates to KCER and CMS on two facilities located on Kauai, Hawaii, related to flooding and mudslides that occurred on April 17, 2018. Neither of the facilities and no patients were affected by the flooding.

### **May 2018:**

- **Kilauea Volcano Eruption**

On May 5, 2018, the Network began monitoring and reporting on the Kilauea Volcano eruption, located on the Big Island of Hawaii. The one dialysis facility located in the region was not affected by the eruption. Some roads were impacted, but all patients were able to get to treatment during the course of the incident.

## July 2018:

- **Yolo Wildfire**

The Network began monitoring the Yolo wildfire, located in Yolo and Napa counties in Northern CA, on July 24, 2018. Four facilities located in the region were monitored but not affected, but road closures made it difficult for two patients to get to treatment on their designated day. Both patients were re-directed to other facilities for treatment the next day. The Network remained in contact with the facilities until the patients were able to receive treatment.

- **Carr Wildfire**

The Carr fire started on July 23, 2018, in Shasta, Trinity, and Mariposa Counties, in Northern CA, and led to road closures and the mandatory evacuation of the city of French Gulch. The Network began contacting and monitoring four nearby facilities on July 24, 2019. A number of patients and staff were impacted by evacuations, road closures, and home loss. One dialysis facility lost power. All facilities were back to operational status by July 28, 2019.

## August 2018:

- **Mendocino Complex Wildfire**

The Mendocino Complex fire began in River, Lake, and Mendocino Counties on July 30, 2018. Network 17 staff provided outreach and support to four facilities in the region. One facility was evacuated and diverted their patients to two of the three additional facilities in the area that remained operational during the incident. The Network monitored the incident, as well as patient and facility status, until August 8, 2018, when the evacuated facility was able to re-open.

- **Hurricane Lane**

The Network began providing outreach and support to Hawaii dialysis facilities related to Hurricane Lane on August 21, 2018. The Network attended daily KCER collaboration calls and monitored the open and closed status of all facilities in the affected area. Facility and patient status reporting was also provided to CMS daily. One dialysis facility closed temporarily due to a brush fire that occurred shortly after the storm passed. The incident concluded on August 28, 2018, with all facilities operating under normal conditions and with all patients accounted for.

## September 2018:

- **Delta and Hirz wildfires**

The Network monitored facility and patient status and communicated with KCER regarding the Delta and Hirz wildfires from September 6–9, 2018. The fires impacted roads in the area, but the local dialysis facility was able to continue to operate under normal conditions throughout the incident.

- **Hurricane Olivia**

The Network began facility outreach and support related to Hurricane Olivia, along with collaborative reporting with KCER and Hawaii dialysis facilities, on September 7, 2018. All facilities experienced minimal impact and resumed normal operating conditions, with all patients accounted for, on September 13, 2018.

- **Typhoon Mangkhut**

The Network monitored the status of facilities in Guam and Saipan related to Typhoon Mangkhut and provided updates and reporting to KCER from September 7–9, 2018. The facilities located in Guam required generator power for four days following the storm, and all patients received scheduled

treatments. The Saipan facilities experienced minimal impact and were able to resume normal functions the day following the storm.

## **October 2018:**

- **Typhoon Yutu**

The Network began facility outreach and support to the Guam and Saipan dialysis facilities related to Typhoon Yutu on October 23, 2018. Facility planned closure information, generator and water status, and back-up staff contact information was collected ahead of the storm making landfall. After the storm passed, the Network communicated with the facilities regarding water and generator fuel needs and patient status.

The Guam facilities experienced minimal impact and resumed normal operating conditions, with all patients accounted for, on October 25, 2018. The Saipan facilities experienced an extensive loss of power and water, with both facilities running on generator status and one facility requiring a water tanker immediately after the storm passed. Both re-opened on generator power and with a modified schedule on October 26, 2018 and continued operating in this status through December 3, 2018.

## **November 2018:**

- **Camp Fire**

Network 17 monitored and reported on the open and closed status of four facilities within 20 miles of the Camp Fire in Butte County in Northern CA starting on November 8, 2019. Multiple patients and staff were evacuated from their homes, and one facility closed for a day due to a power outage. All facilities were open with regular operations on November 13, 2018.

## ACRONYM LIST APPENDIX

This appendix contains an acronym list created by the KPAC (Kidney Patient Advisory Council) of The National Forum of ESRD Networks. You can access the acronym list on [The National Forum of ESRD Networks website](#). 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.