



ESRD Network 2020 Annual Report

ESRD Network 18
Southern California

Comagine
Health

Table of Contents

ESRD DEMOGRAPHIC DATA.....	3
ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA.....	10
ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA	14
Long Term Catheter Quality Improvement Activity.....	14
Blood-Stream Infection Quality Improvement Activity.....	17
Transplant Waitlist Quality Improvement Activity	22
Home Therapy Quality Improvement Activity.....	25
Population Health Focus Pilot Project Quality Improvement Activity.....	28
ESRD NETWORK RECOMMENDATIONS.....	32
ESRD NETWORK COVID-19 EMERGENCY PREPAREDNESS INTERVENTION	34
ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION.....	36
ACRONYM LIST APPENDIX.....	38

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ESRD DEMOGRAPHIC DATA

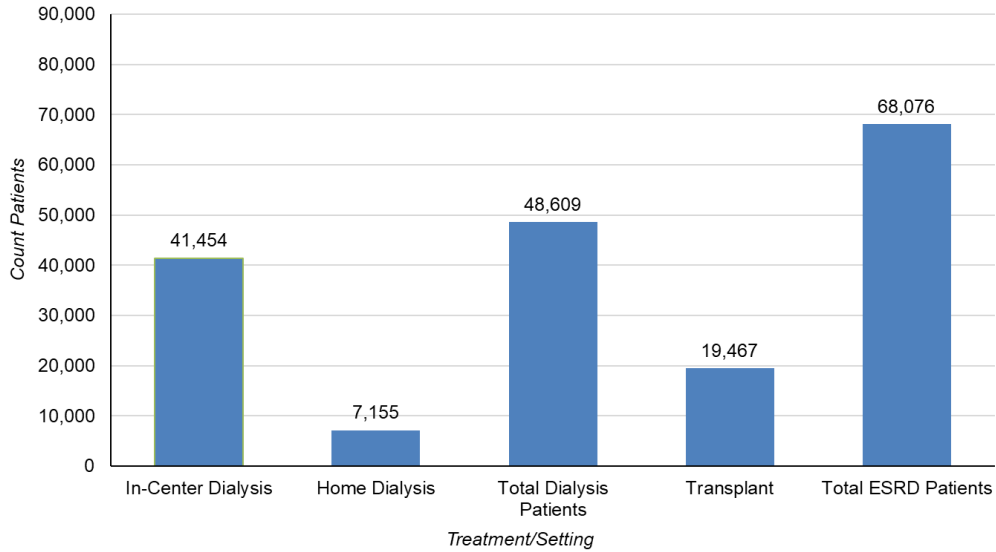
Comagine Health's ESRD Network 18 territory is comprised of thirteen counties in Southern California including Inyo, Tulare, Kings, San Luis Obispo, Kern, Santa Barbara, Ventura, Los Angeles, San Bernardino, Riverside, San Diego, and Imperial counties. The general population in these counties represents 62% of California's total population, according to the U.S. Census estimates as of July 2019.

Network 18 has a combined estimated general population of 24.5 million. As of December 31, 2020, there were 448* Medicare certified dialysis centers situated in urban and suburban areas throughout the 13 counties and 13 transplant centers located in the major urban areas. The Network 18 service area contains three of the nation's six most populous counties, including Los Angeles, San Diego and Orange counties. Los Angeles county, which is 13 square miles, houses 212* (46%) of the total Network's dialysis facilities and 46% of the entire population in Network 18. The service area is very diverse with rural farming areas and sparsely populated remote desert and mountain areas, as well as the densely populated cities. It is expected the population in this area will meet or exceed the national growth rate in the next few years. Network 18's service area is characterized by significant ethnic and cultural diversity. There are 224 languages spoken in this region. The six languages that are spoken the most in Los Angeles County are English, Spanish, Tagalog, Korean, languages of China, and Armenian. Spanish is the most spoken, non-English language in every county in California except for San Francisco.

Network 18 was the third highest of the nation's Networks in total number of prevalent patients dialyzed during the year and is ranked as the eighth highest network according to the number of dialysis facilities operating in 2019. The Network prevalent population consists of 46,863* ESRD patients and 19,456* transplant recipients and is comprised of 49% Hispanic or Latino. Diabetes and hypertension are the primary causes of ESRD for prevalent patients.

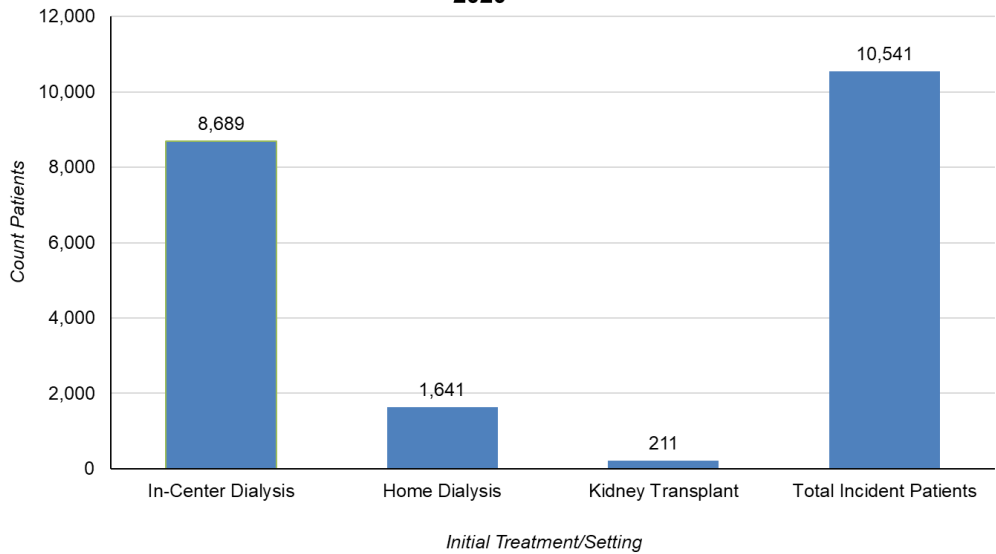
* Estimates are based on 2020 EQRS 2744 Annual Facility Survey data as of May 13, 2021.

**Network 18: Count of Prevalent ESRD Patients by Treatment/Setting
2020**



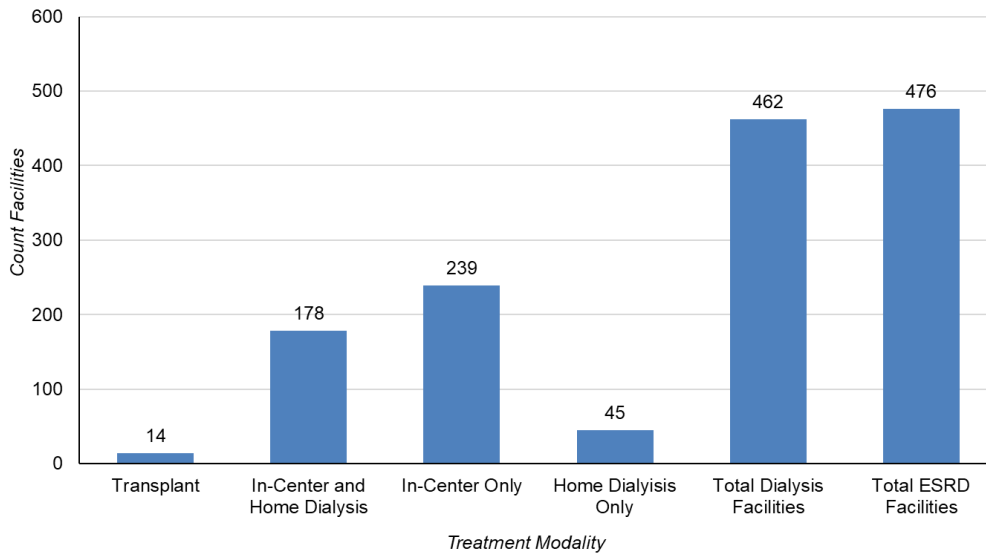
Total Dialysis Patients = In-Center Dialysis + Home Dialysis
 Total ESRD Patients = Transplant + Total Dialysis
 SNF dialysis patients are not shown due to small numbers.
 Source of data: EQRS accessed June 21, 2021

**Network 18: Count of Incident ESRD Patients by
Initial Treatment/Setting
2020**



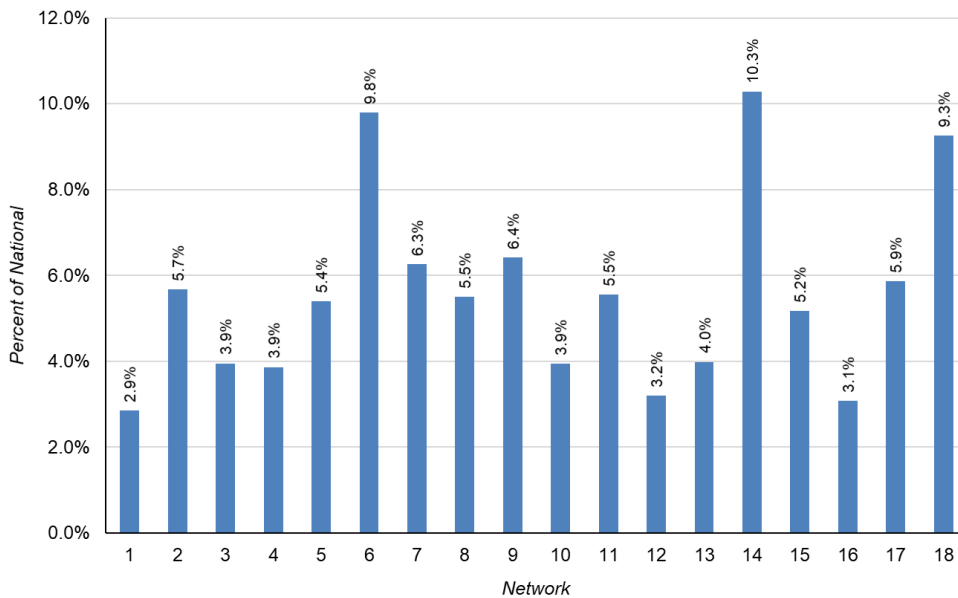
Total Incident Patients = In-Center + Home + Kidney Transplant
 Source of data: EQRS accessed June 21, 2021

**Network 18: Count of Medicare-Certified Facilities
by Treatment/Setting
2020**



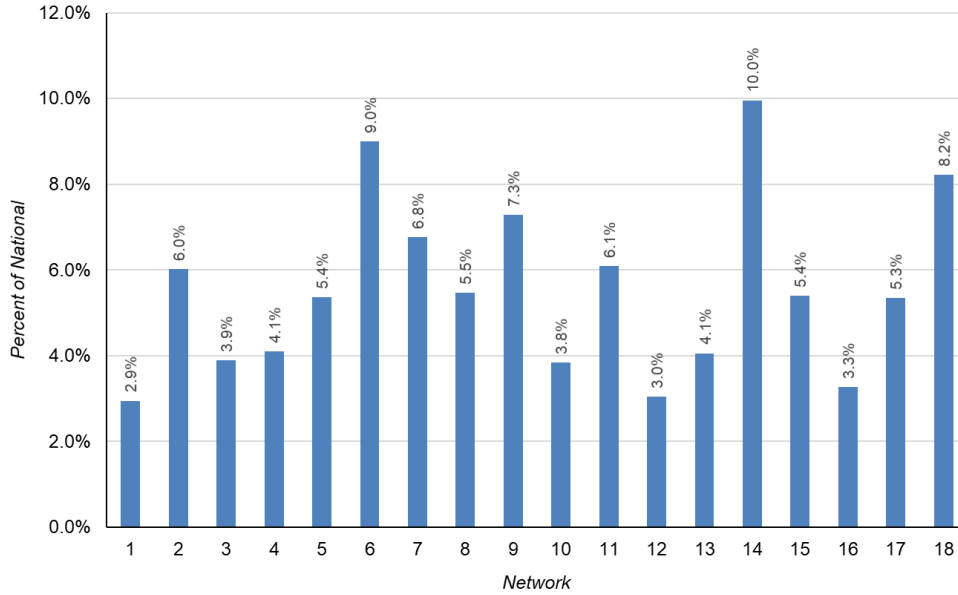
Total Dialysis Facilities = In-Center and Home Dialysis + Home Dialysis Only + In-Center Only
 Total ESRD Facilities = Transplant + Total Dialysis Facilities
 Source of data: EQRS accessed June 21, 2021

**Percent of National Prevalent Dialysis Patients by ESRD Network
2020**



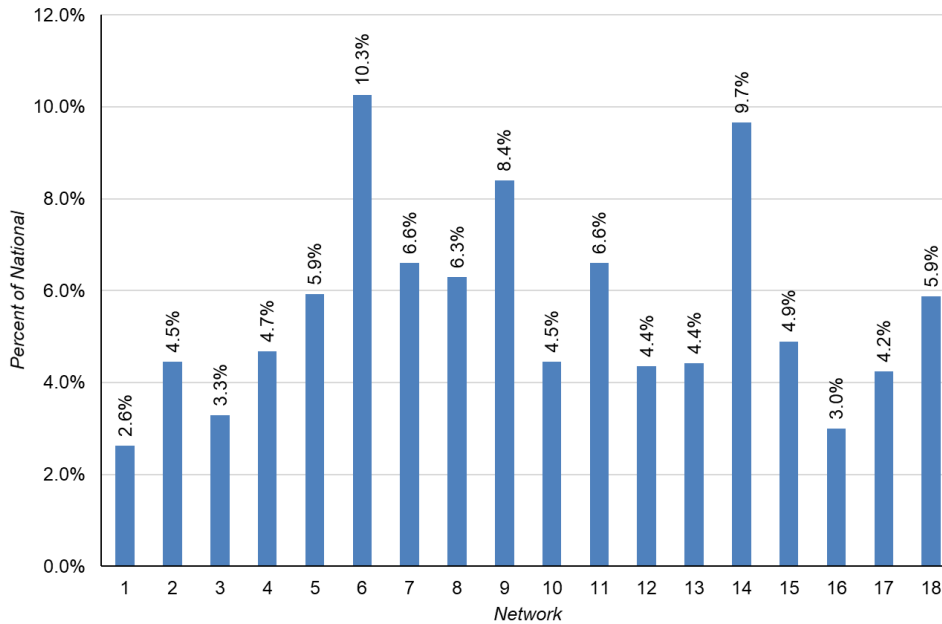
National total dialysis patients: 525,148
 Source of data: EQRS accessed June 21, 2021

**Percent of National Incident Dialysis Patients by ESRD Network
2020**



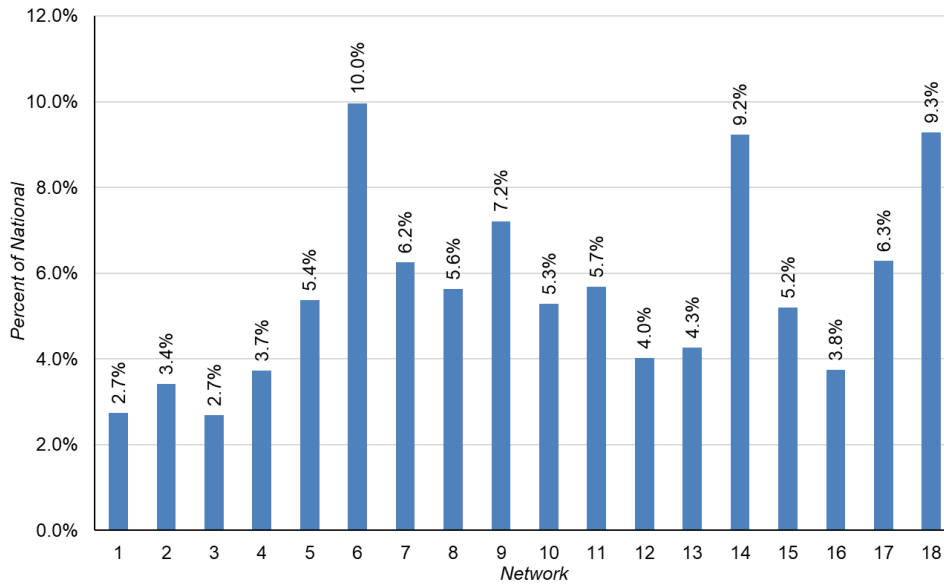
National total incident patients: 128,323
 Source of data: EQRS accessed June 21, 2021

**Percent of Medicare-Certified Dialysis Facilities by ESRD Network
2020**



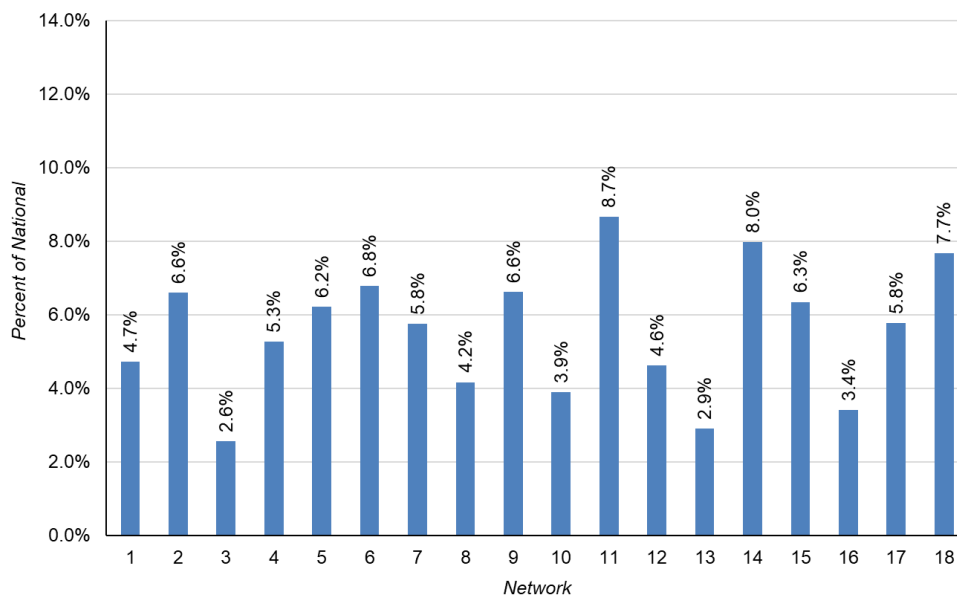
National total ESRD Medicare-certified dialysis facilities: 7,864
 Source of data: EQRS accessed June 21, 2021

Percent of National Home Hemodialysis and Peritoneal Dialysis Patients by ESRD Network 2020



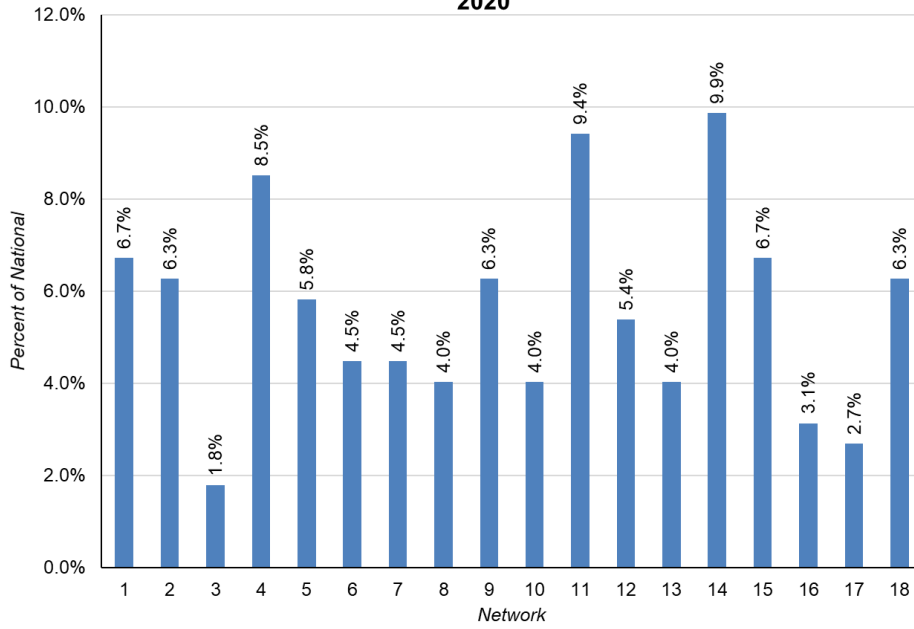
National total home hemodialysis and peritoneal dialysis patients: 77,131
 Source of data: EQRS accessed June 21, 2021

Percent of National Transplant Patients by ESRD Network 2020



National total transplant patients: 253,487
 Source of data: EQRS accessed June 21, 2021

**Percent of Medicare-Certified Kidney Transplant Facilities by ESRD Network
2020**



National total ESRD Medicare-certified kidney transplant facilities: 223
Source of data: EQRS accessed June 21, 2021

ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA

ESRD Network 18 has a unique culture unlike any other Network in the county. We have one of the largest patient populations in one of the smallest geographical areas. There is a great deal of racial and ethnic diversity in Southern California with hundreds of languages being spoken across our service area. Southern California is predominantly urban which further adds to that unique culture and leads to a high volume of grievances as well as issues of conflict in the dialysis setting. In 2020 Network 18 received a total 578 individual cases, a decrease of almost 100 from the previous year (67 Access to Care, 28 Clinical Quality of Care, 30 General Grievance, 35 Immediate Advocacy and 418 Facility Concerns).

Grievance

A great deal of effort has been placed on improving the overall care provided at a unit whenever a single grievance is filed. Overall, the number of grievances received from 2019 to 2020 has decreased, which may be an indication that these efforts over the past several years has been successful. Network 18 has worked tirelessly to encourage dialysis staff to engage their patients in their care and to provide care that always holds the patient at its center. Doing this work requires that patients are not only heard but encouraged to speak up when they have concerns. Additionally, it is the hope that patients feel comfortable to report their concerns at the facility level and only require Network intervention for extreme cases that cannot first be resolved internally. While it is never required to first try and resolve concerns at the facility level, it is encouraging to know that the facility culture is shifting to one that provides a safe environment for patients to speak up. It is also possible that with all that 2020 had to offer, there was a shift in priorities, and perhaps a new understanding for the patient staff relationships that has lent itself to improve the way we all relate to each other.

2020 was a unique year as society dealt with a global pandemic as well as a great deal of civil unrest. Initially when the pandemic first began, we saw an uptick in patients calls related to the safety protocols in place for COVID-19 screening and cohort units for suspected and confirmed cases of COVID-19 in the dialysis population. Patients were acutely aware of the situation and wanted to ensure that they were being treated in the safest environment possible. As the year progressed the frequency of these calls slowed down, and people seemed to settle into the new norm.

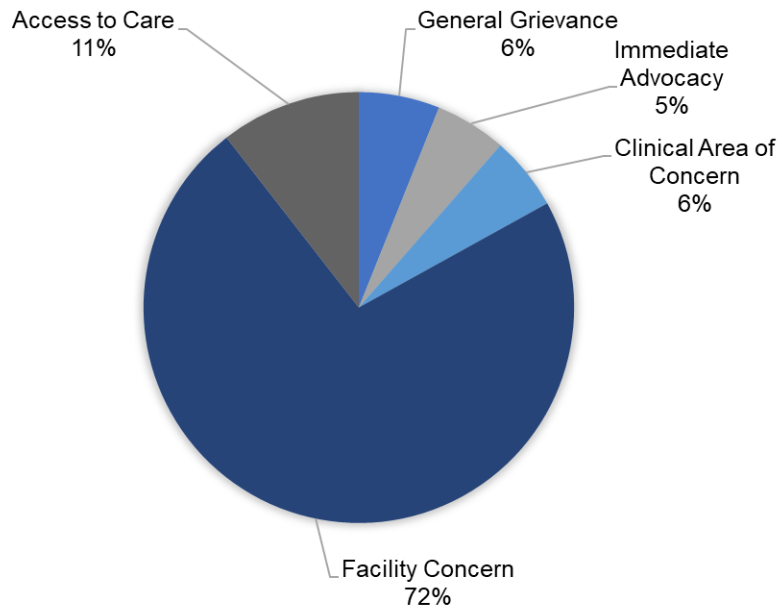
Access to Care

There were 67 cases filed with regards to patient access to care in 2020. 57 of those cases were discharge cases. Of those 57 cases, 19 Involuntary Discharges (IVDs) occurred, meaning that the Network has a 66% success rate of averting IVDs. It is important to note that 15 of the IVDs were due to Immediate Severe Threat, meaning the patient was immediately discharged from the unit without warning due to actions or behavior that were seen to put the facility, patients and staff in immediate jeopardy for serious harm. Because these happen quickly, and the Network is often notified after the IVD occurred, these are extremely difficult to avert. There were no IVDs due to nonpayment as facilities did not discharge patients for nonpayment during the pandemic. Of the IVDs that did occur 8 were Black individuals, 7 were White Hispanic, 3 were White non-Hispanic, and 1 was Asian. It is important to note that while Black patients make up 42% of the IVDs that occurred in 2020, they make up approximately

12% of the entire patient population in Network 18. It undeniable that a disproportionate number of black patients are being forced out of their dialysis facilities against their will.

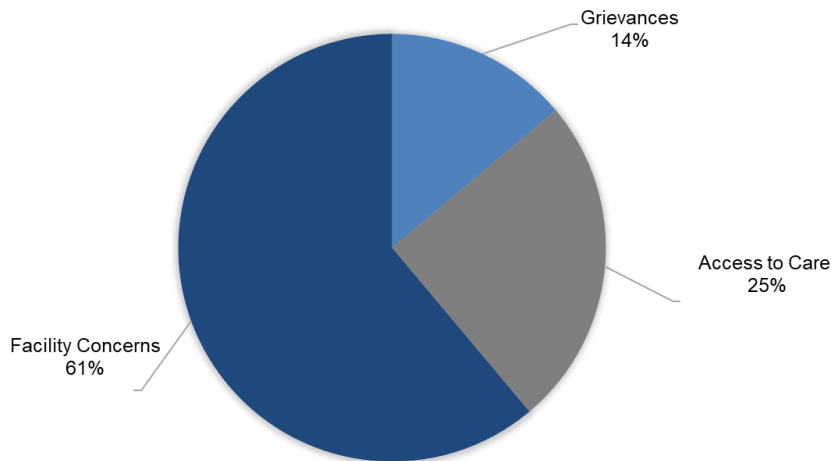
It is our belief that in addition to the above-mentioned racial disparity, the vast majority of IVDs occurred because of poor communication and an inability to deescalate a situation that ultimately leads to a conflict between a patient and a staff member. Dialysis treatment staff have limited time, skills and training in conflict resolution and how to manage individuals who are dealing with a wide range of mental, emotional and psychosocial factors. Lacking the tools to properly manage these situations can lead to an unsafe treatment environment for patients and staff alike. Most importantly, dialysis patients who are discharged against their will become very hard to place and are at increased of mortality when access to dialysis in an outpatient setting is limited or impossible to establish. There is a great deal of work that needs to continue to be done to address these deficits for our dialysis population in Southern California.

**Network 18: Percent of Grievances and Non-Grievances
by Case Type
December 2019 - December 2020**



Source of data: Patient Contact Utility (PCU) accessed April 2021

**Network 18: Percent of Mental Health Related
Grievances and Non-Grievances by Case Type
May 2020 - December 2020**



Grievances include Immediate Advocacy, General Grievance, and Clinical Quality of Care
Source of data: Patient Contact Utility (PCU) accessed April 2021

ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA

Long Term Catheter Quality Improvement Activity

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

Project Restructure

This year the Network revolutionized the traditional project structure with a responsive activity structure called “Putting Patients First” which centers on individualized care planning for vascular access management. Participants in the long-term catheter project demonstrated strong understanding of patient-centered care in removing CVCs. Innovations include focus on patient plan of care, 1:1 nursing report for CVC facilities, an original best practice resource, and tracking new data for analysis of CVC removal barriers.

Pandemic Adaptability

In the tumultuous pandemic environment, the Network responded with education and targeted technical assistance to disseminate changes in CMS expectations. Facing limited access to vascular surgeons and interventional procedures, the Network provided advanced clinical education to our nurses based on the latest KDOQI guidelines to promote best practice in fistula assessment for RNs, to prevent conversions to CVC and reduce preventable procedures in the PHE environment. Network 18 in May held a collaborative webinar with LA County SSA to educate and roll out county-wide plan to assess readiness to admit COVID+ patients and establish communication triad with SSA and facilities during rollout and implementation to support infection prevention QI as needed.

Variety of Educational Resources

Resources were identified from a multitude of sources. NCC LANs provided interventions in infection prevention from fellow clinics and widened the distribution of best practices, such as tips for more efficient CVC dressing changes. Furthermore, the CDC identified discrepancies in the CVC infection data and pushed this year for standardized blood culture collection practices in dialysis. The Network refocused infection prevention education accordingly on standardization and best practices in blood culture collection and how it affects CVC infection rates. The Telemedicine Rapid Response initiative assisted providers in understanding, utilizing, and billing for telehealth to support opportunities such as vascular surgeons to do telehealth visits for permanent access placement and catheter removal. In May, their telehealth initiative assisted with billing info for vascular surgeons to do telehealth follow up visits for permanent access placement and catheter removal.

Integrative Feedback Processes

The Network has continuously provided an open environment of staff feedback to evaluate the effectiveness of interventions and directly from patients themselves via the SME network. Facilities and patients both provided feedback on effectiveness of tools and resources provided, and all patient education was reviewed by the PAC. Patient SMEs were recruited in all project participants with monthly

requirements for staff to engage them in specific activities. The Network required patient participation in QAPI and for patients to use CDC put-on/take-off check lists to audit staff for CVCs. Participants were expected to demonstrate strong understanding of patient-centered care in supporting patient adherence to keeping appointments to support timely removal. Patients with chronic catheters overwhelmingly cite feeling coerced out of choice in access and having medical contraindications for CVC removal; they feel unheard and unacknowledged in the "war" on catheters. The Network responded with educational interventions that promote informed patient choice in access options to prevent ongoing stigma of CVC patients.

Best Practices and Barriers

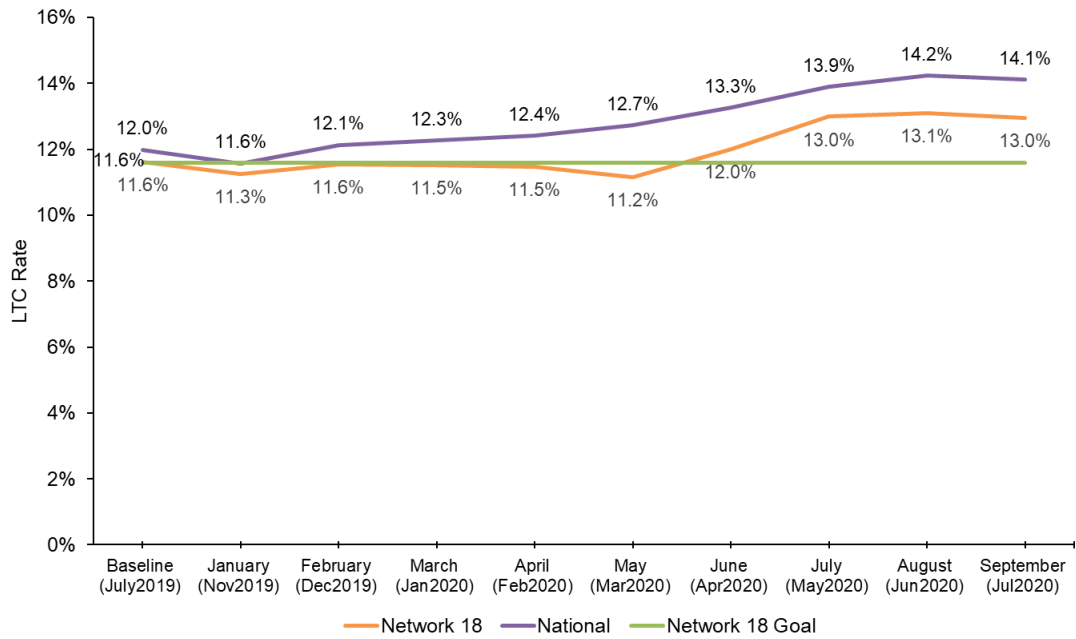
Additionally, the Network proactively sought best practices on refusals and appointment support based on facility-identified needs and compiled/distributed these BDPs. Top performers were identified as having a 'CKD Coordinator' to proactively manage the plan of care to improve CVC removal. Best practices were promoted that originated with the facilities and an original resource was created to disseminate practices such as one that three separate facilities identified: using software that alerts staff to abnormal trends in patient access function. Since wide-spread adoption of the FFCL is inherent across the industry, the most effective intervention was found to be one-on-one conferences with each participant. For those without access to corporate resources, the Network utilized the AKF "First 30" Toolkit in July to support transitions of incident patients and decrease time to CVC removal. Incident patients account for more than 90% of patients with a CVC and need support in the steps to removal. Network 18 in March identified Olive View, a MediCal (CA Medicaid) facility, emerging as a major regional barrier to CVC removal among MediCal patients due to wait times, repeated revisions for poor quality access, and low responsiveness of staff, this issue was coordinated with the state Medicaid agency in order to counter the increasing trend of refusing Medicaid-only new admissions.

Data Accuracy and Integrity

Rethinking data collection proved a new area of opportunity. Facilities were required to watch the Network-recorded video on correctly reporting vascular access data into CROWNWeb in order to reinforce basic expectations in an environment of high turnover. Analysis of Environmental Scan results revealed best practices according to facilities center around timely internal workflow. In response, the Network reimagined data collection on CVCs to include information not available in CROWNWeb, such as count of revisions and chronic CVCs.

This data provides an actionable foundation for improving care coordination with hospitals and vascular surgeons: all facilities struggle with not being able to start the removal process for new patients prior to admission and universally state that the 90-day removal expectation is unrealistic. Data collection on barriers revealed systemic barriers continue to impede progress below 15% long term CVC rate for many individual facilities, although the Network-wide average ranges from 10-11%. These barriers include lack of vascular surgeons to perform procedures, Medicaid barriers (such as AppleCare restrictions to one surgeon in LA county and requiring additional procedures making it effectively a one-year average CVC removal time), and patients feeling coerced into getting a fistula rather than having a choice.

Network 18: Long-Term Catheter Rates January 2020 - September 2020

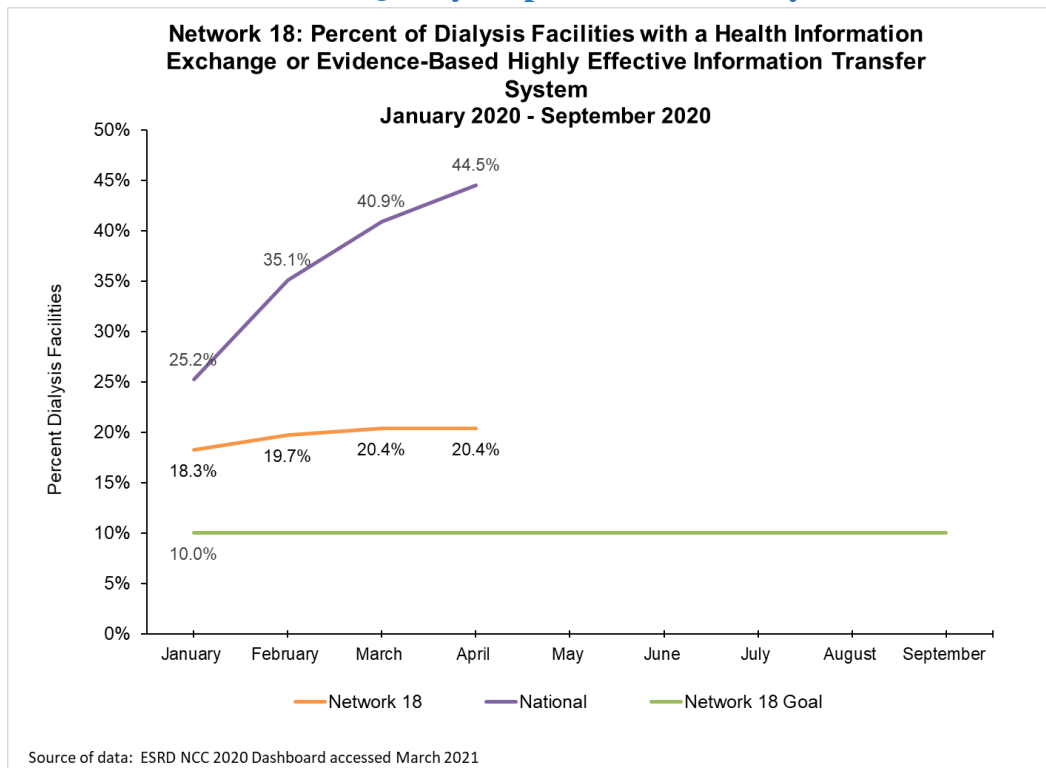


X-axis: Reporting Month (Data Month)

QA: Quality Improvement Activity

Source of data: ESRD NCC 2020 Dashboard accessed March 2021

Blood-Stream Infection Quality Improvement Activity



Project Restructure

In 2020, the Network launched a dynamic framework for QI projects in which all facilities focused on better care planning in the “Putting Patients First” initiative. It emphasizes individualized care planning based on outcomes and not just check boxes. Innovations include focus on patient plan of care, QAPI integration step by step guide, best practice resource, and SME infection champions. The care plan focus QIA structure allowed for flexibility in identifying and responding to needs. Network 18 met the 80% goal in influenza vaccinations thanks to early head start prior to flu season with Network hitting 83% prior to deadline.

Pandemic Adaptability

The pandemic environment of constant change and stress made it difficult to follow all guidelines at all times. In June the Network held a webinar for providers on ways to manage stress and crisis for HCP. To support their success, patient SMEs were recruited in all project participants with monthly requirements for staff to engage them in specific activities. QAPI participation was one of those activities; the Network established boundaries and reinforced expectations. Patients conducted CDC put-on/take-off audits as well. Facilities are encouraged to aim for their goals using a whole-team approach with a formal support structure in the form of policies/procedures.

Root Cause Analysis as the Foundation of QI

RCA was used at the onset of the project with every participant, and then individually as needed with participants who, under regular monitoring, were found to be underperforming. RCA came in written and digital formats, in addition to individual guidance with NW staff on the phone or in person. RCA data was used to provide guidance on foundation of strong PDSA cycles with monthly follow up as needed. In collaboration with LDOs, individual RCA was performed on facilities that underperformed last year. RCA revealed need for flu readiness in pandemic environment, leading to Flu Precautions toolkit with ready-made CDC guidelines to in-service staff, resources to share with patients, and tools to communicate with SNF/hospital. In the tumultuous pandemic environment, the Network responded with education and targeted technical assistance to disseminate changes in CMS expectations.

Collaboration and Connectivity

While nationwide efforts are underway to connect the acute and chronic settings over the next few years, this Network continues to encourage facilities to find ways to reduce harms more immediately. Network 18 collaborated with LA County surveyors and CA state HAI specialists to provide robust data validation and individualized education/support for implementing CDC audit tools. We also worked with the California state HAI team to address NH issues such as cohorting, transportation, and communications. In May, Network 18 held a collaborative webinar with LA County SSA to roll out their readiness assessment plan for COVID+ patients. We established a communication triad with the SSA and facilities during implementation to support infection prevention QI as needed. The Network has worked to improve communication between the acute and chronic setting as well, promoting best practices such as timely records retrieval, participation in infection prevention collaborations, and RN handoffs. EMR/HIE access documentation provided evidence of permanent adoption of best practice in post-hospitalization patient care. Data was collected and analyzed for successes and barriers monthly. Technical support was provided with facilities to clarify requirements and knowledge around HIE and NHSN using HEALTHIT.gov materials as reference to further highlight the value and need for better interoperability.

Variety of Educational Resources

PFE LANs were instrumental in providing patient-reviewed resources from points of view outside the PAC and SME pool (such as the NCC NPFE patient-created resource, the Clean Hands Count badge). The Network was one of the first to participate in the collaborative effort with all Networks to produce an effective hand sanitizer audit tool for dialysis at CMS' request, which was subsequently implemented in their facilities by August. All nine core interventions were incorporated in a monthly education plan with supportive resources and diligent project monitoring/follow up. The Network provided staff education on 3-step plan to integrate CDC Core Interventions into monthly QAPI using simplified regulations, follow up, and PDSA documentation for easy applicability for time-strapped staff.

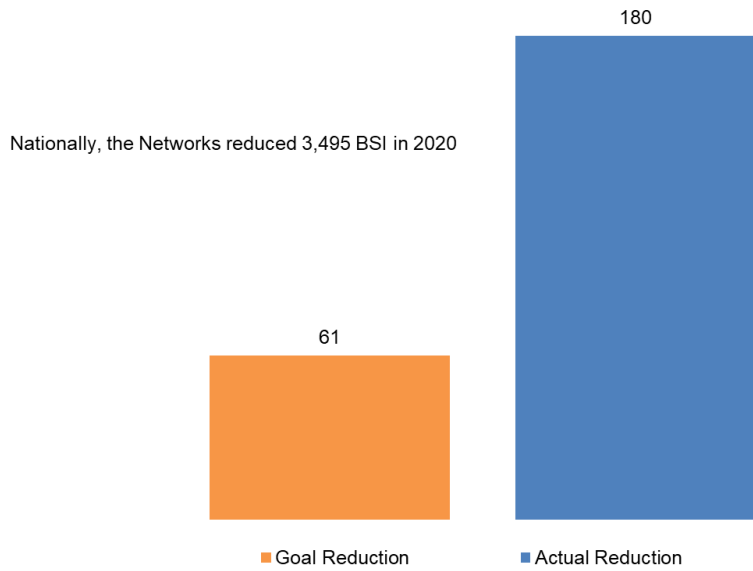
The Network utilized numerous CDC educational tools including annual NHSN training, Core Interventions, and Dialysis Audit Tools. This Network promoted evidence-based practice based on updated guidelines coming from recent research conducted by the CDC; wall box cleaning and disinfection guidance were provided with supporting documentation and follow up to ensure adoption. The Network continuously sought staff and patient feedback to evaluate the tools and resources

provided. Educational materials for patients were provided in English and Spanish based on the needs of the population, and other languages as available or requested.

NHSN Support and Technical Assistance

The Network supported NHSN data accuracy consistent with regulatory changes in the PHE environment and in day-to-day technical assistance, in addition to educational resources on PPM, DE protocol, QIP requirements, annual training, etc. With the November launch of weekly required reporting, the Network launched a complex structure for education and support with relentless follow up and the Network was able to show over 90% compliance within 30 days. Furthermore, despite a pervasive belief among the NWs that NHSN cannot provide any disparity data, the Network provided CMS with the means to collect demographic data from NHSN for future incorporation into the BSI project. This data includes age, gender, and ethnicity, but does not include race or rural/urban status.

Network 18: Reduction in Bloodstream Infections (BSI) in QIA Facilities

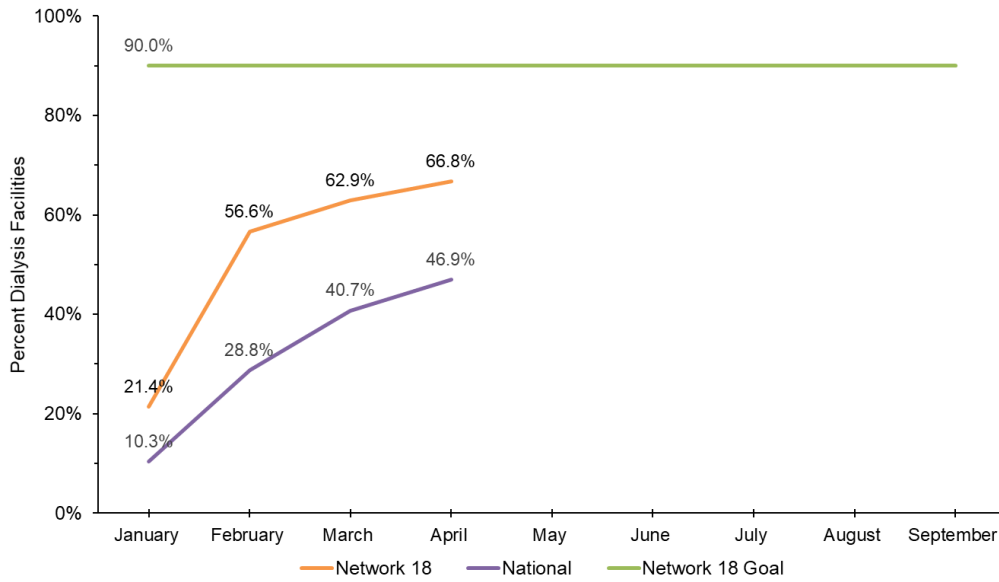


The Network goal was to decrease the rate of BSI by 20% or greater relative reduction in the pooled semi-annual mean in facilities participating in the QIA

QIA: Quality Improvement Activity

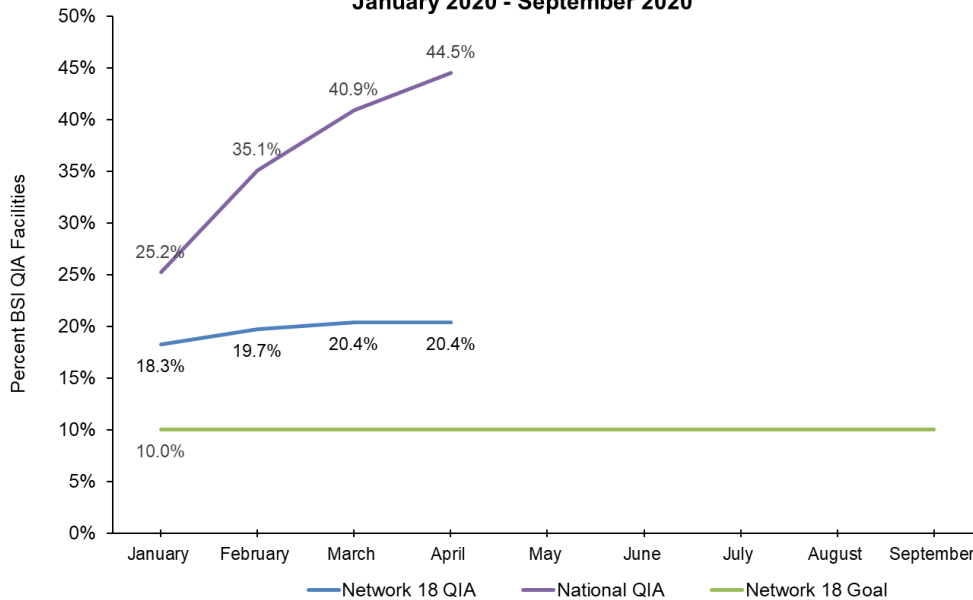
Source of data: National Healthcare Safety Network (NHSN) January 2020 - June 2020 compared to January 2019 - June 2019

**Network 18: Percent of Dialysis Facilities with At Least One Person Who Has Completed the NHSN Dialysis Event Surveillance Training
January 2020 - September 2020**



Source of data: ESRD NCC 2020 Dashboard accessed March 2021

**Network 18: Percent of BSI QIA Facilities with a Health Information Exchange or Evidence-Based Highly Effective Information Transfer System
January 2020 - September 2020**



QIA: Quality Improvement Activity
BSI: Bloodstream Infection

Source of data: ESRD NCC 2020 Dashboard accessed March 2021

Transplant Waitlist Quality Improvement Activity

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

Project Overview and Goals:

The Network's Transplant Waitlist Quality Improvement project for 2020 focused on increasing the rate of patients on the Transplant waiting list by 1.25%. To achieve this goal, the Network utilized the ABC methodology to identify facilities that were top performers and low performers. The Network selected 159 low-performers and project focus facilities.

Project Activities:

The Network project focused on "Putting Patients First" which emphasized the need to include transplant waitlist options in individualized care planning meetings with patients. The Network focused on educating the low-performing facilities on the benefits of a transplant modality, patient options for receiving a transplant, and on improving discussions between facility staff and patients. For example, educating staff on how patient perception and readiness to learn impacts modality choices. After this improvement was made, the Network activities shifted focus to reducing barriers inhibiting each individual patient from pursuing a kidney transplant.

Interventions:

The Network convened a **Dual Network Transplant SME Coalition** to collaborate on strategies for improvement. Network Transplant Coalition successfully identified key systemwide challenges and strategized on network specific interventions and QI opportunities. Key challenges addressed throughout the year included: Patient Adherence to treatment, patient disinterest in transplant due to long wait times, and financial barriers. Interventions were identified and developed based on the results of the Network environmental scan, feedback from PAC Transplant Advisors from all five states, Medical Review Board input and literature review. Network 18 transplant project implemented interventions such as, the use of an Online Learning Management System, Transplant QIA Project Facility Technical Assistance, Dual Network Transplant SME Coalition, Patient Engagement Activities.

Online Learning Management System: The Network developed a Transplant Resource Book in our online learning management system (LMS). The Transplant Resource Book is a repository of best practices and interventions created by the Network and by industry partners such as the NCC, NKF, CMS and UNOS. The Network ensured patient level educational materials were made available in both English and Spanish. The Transplant Resource Book has been accessed more than NW18 25.8K times by facilities throughout the year. The top resources accessed by facilities includes:

- Most popular resource was the direct contact information of the transplant centers. NW18 1580
- Transplant Center Criteria Matrix: NW18 1357
- Transplant Candidates - Now is the Time to Check out VR: NW18 879
- Overcoming Barriers to Waitlisting Best Practices series: NW18 2410.

Overcoming Waitlist Barriers & Best Practices: Using the barriers to wait listing information was collected from the Environmental Scan, the Network asked the top-performing facilities on how they

overcome these barriers and aggregated their responses into a collection of Best Practices that were shared with all facilities, including the low-performing focus group. Best Practices were rolled out monthly and were accessible to all facilities in the Network's online learning system Transplant Resource Book:

- Transplant Waitlist Best Practices Part 1: Overcoming Financial Barriers: NW18 403
- Transplant Waitlist Best Practices Part 2: Overcoming Patients Barriers to Following Prescribed Treatment: NW18 559
- Facility Best Practices Part 3: Long Waitlist Time for a Transplant: NW18 489
- Transplant Waitlist Best Practices Part 4: Patients Barriers to Receiving Pre- and Post-Transplant Support: NW18 224
- Transplant Waitlist Best Practices Part 5: Lengthy Transplant Work-Up Process: NW18 735

Patient Engagement Activities: The Network hosted the annual in person board meeting where staff and Patient Advisory Council members and continuously collaborated with members on the development and use of interventions, including three new NCC resources; *Partnering Along the Road to Transplant*, *Why Transplant is a Good Idea for Me*, and the *Is a Transplant Right for Me? Kidney Transplant Tool Kit*.

Transplant QIA Technical Assistance: The Network conducted 1:1 QI Calls to poor performing facilities to identify current workflow practices and challenges inhibiting success with patient transplant wait listing. The Network successfully identified common systemic barriers and provided strategic guidance and targeted resources and interventions to address specific challenges. Some examples of technical assistance provided includes, referral to specific chapters in the Network's transplant resource book, the use of The National FORUM of ESRD Networks' MAC Transplant Toolkit, and key resources on living kidney donation, high KDPI organs, and best practices to improve tracking of the transplant wait listing process. Through this process, facilities noted an increased interest in transplant as a treatment modality.

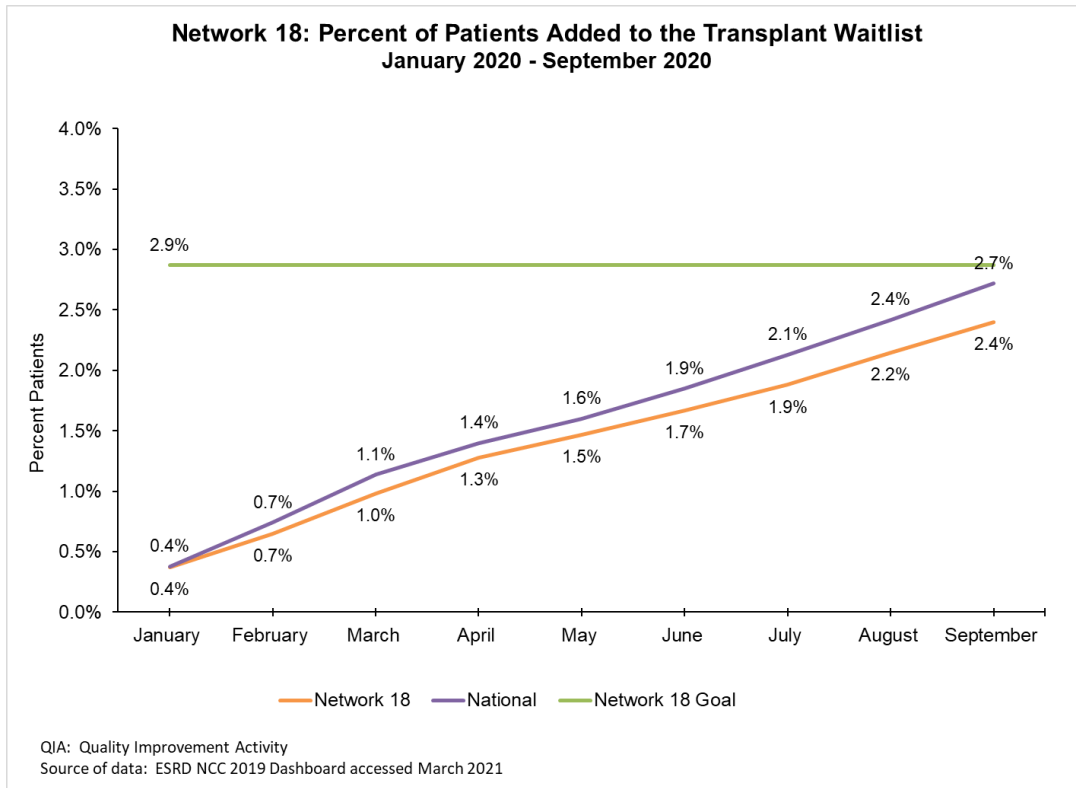
Innovation:

Transplant Center Situational Analysis Survey (Telehealth impacts from COVID-19): Early in the pandemic, the Network recognized a need to identify organizations utilizing telehealth technology. The Network conducted a situational analysis survey which clarified which transplant centers are using virtual visits as a result of COVID-19 and promoted the use of telehealth visits with transplant centers during facility level 1:1 technical assistance. The majority of transplant centers have adopted the use of this technology.

Transplant Waitlist Report: The Network provided dialysis facilities with UNOS reports of patients waitlisted monthly. Facilities were provided transplant center contact information and were trained on how to collaborate with Transplant Coordinators to validate and reactivate (when applicable) "Inactive patients" on the Waitlist. Dialysis facilities were taught how approach patients who were not on the waitlist to discuss their concerns about the waitlist process and to provide patients with appropriate resources that will help them make informed decisions. Transplant waitlist report sent to Transplant Centers was positively received.

Final QIA rate:

2020 was a challenging year for the healthcare industry. In kidney transplantation, many transplant centers halted operations to divert resources to the pandemic and protect patient safety. This led to impacts to patient access to transplant in early Q1 and Q2 of 2020. In addition to these challenges, during Q3, a transition of records occurred between CROWNWeb and EQRS. Resulting in a lack of access to final data from the NCC for 2020 until Q2 of 2021. The Network’s performance from Jan 2020 to October 2020 fell just shy of our goal of 2.87% by 0.17%. However, By the end of Jan 2021 the Network had met and surpassed the baseline by 442 patients and exceeded our goal of 2.87% by 412 patients.



Home Therapy Quality Improvement Activity

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

Project Restructure

The traditional project structure underwent innovation this year by focusing on improvements to care planning in the “Putting Patients First” initiative. Interventional innovations included a heat map for home training, creation of a best practices reference, telehealth education prior to the PHE, a patient communication toolkit, staff education plans, and Network-wide SMEs. The Network's advocacy and support of California's programs for home hemodialysis in NHs are pioneering a new horizon in the dialysis industry to keep these most vulnerable patients out of the hospital. Patient SMEs were recruited in all project participants with monthly requirements for staff to engage them in specific activities, including QAPI.

Root Cause Analysis as the Foundation of QI

The care plan QIA structure allowed for flexibility in identifying and responding to needs. RCA was used at the onset of the project with every participant as part of their staff education plans, Network-wide to assess barriers, and individually as needed with participants who, under regular monitoring, were found to be underperforming. RCA data was used to provide guidance on foundation of strong PDSA cycles with monthly follow up as needed. Network-wide RCA was utilized throughout the PHE such as in April when limited staffing and accessibility of home programs was revealed as exacerbated in the pandemic environment. No elective procedures in hospitals put a stop to patient transitions and RNs from home programs were mobilized to work in-center, no longer available to provide education and training. The Network responded accordingly with interventions aimed at sustainability and greater impact with less burden.

Top performers revealed significant reliance on the medical director as the leader of home transitions. This makes application highly variable in mobilizing the care plan in a timely manner, unless the nephrologist is proactive with colleagues. The Network responded with a communication toolkit to empower patients to self-advocate for their personal priorities. The Network polled facilities that cited staffing issues as a top barrier to placing patients in home programs, so interventions were formed with sustainability in mind. Facilities were encouraged to aim for their goals using a whole-team approach with formal support from policies and procedures.

An April needs assessment on telehealth led to formation of a Telemedicine Rapid Response initiative to assist providers in understanding, utilizing, and billing for telehealth to support opportunities such as follow up visits for home access placement. Furthermore, the Network addressed an existing knowledge gap by providing a framework for education and follow through. We provided ongoing updates on infection control guidelines from the CDC to promote home patient retention.

Collaborative Efforts with Stakeholders

Home patients, the Network PAC, Home Dialyzers United, Renal Support Network, and Homedialysis.org all provided support and valuable patient insight to facilities by serving as resources for patient and staff education. Collaboration with MEI led to the innovative "Teachable Moments" webinar/recording to

raise understanding of patient perception, modality choices, and readiness to learn. In July and August, the Network released a PAC-advised toolkit to address common pitfalls in communication. Throughout the pandemic we provided ongoing updates on infection control guidelines from the CDC to promote home patient retention. In July the Network collaborated the QIO NH team to assist providers in education and coordination of patient transitions and infection prevention through virtual education events, creation of a protocol template, and identifying gaps in educational resources.

The Network collaborated with LDO home programs throughout the Network for an aggressive push towards lofty goals. Network 18 exceeded 70% goal in telehealth vaccinations prior to the June deadline. All in-center participants partnered with nearby home programs to conduct onsite education prior to the pandemic and improve care coordination. The innovative heat map supported the effort with the LDOs, highlighting areas of opportunity. The Network held LDO leadership calls throughout the year to discuss opportunities for modality education and opportunities in acute dialysis services. The Network sought patient feedback both from facilities evaluating the effectiveness of interventions and directly from patients via the SME network. Patients expressed that home modalities education efforts were too aggressive, so the Network responded with an interventional toolkit on communication to address patient priorities that approach home modalities from different angles.

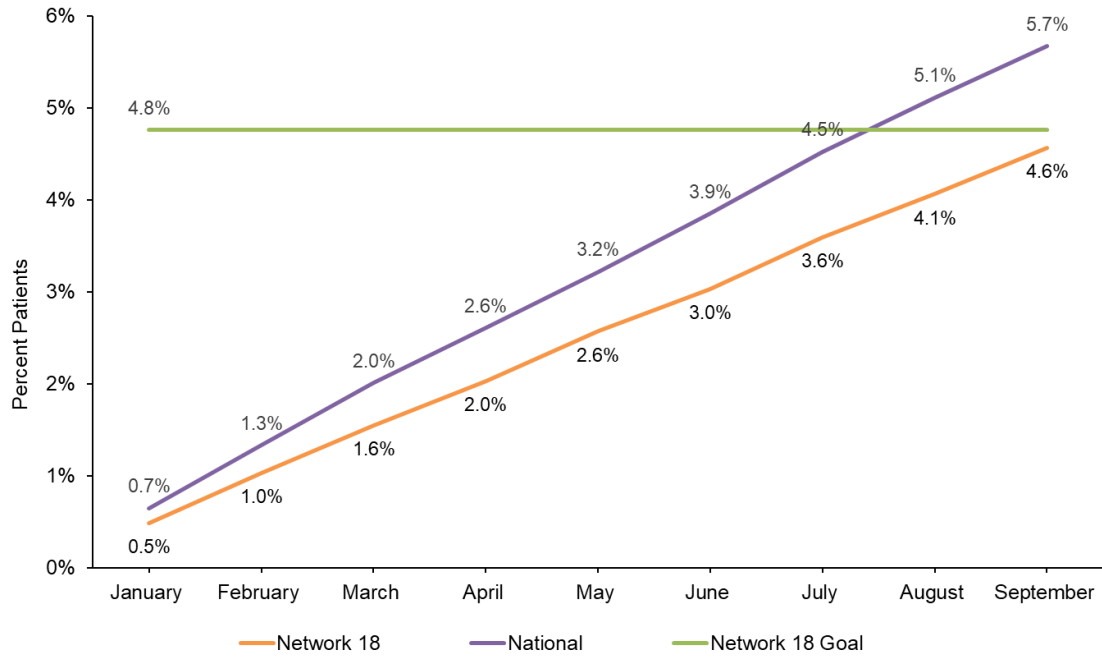
Robust Patient Engagement

Patients provided feedback on refusal reasons to identify intervenable root causes. PAC provided foundation for patient education materials created by the Network. PFE LANs were instrumental in providing points of view from outside the PAC/SME pool and additional resources such as the "Let's Talk" Questions Card Deck. NCC LANs provided interventions in home modality infection prevention such as use of the educational tool called a "dummy tummy" and widened the distribution of best practices. Educational materials were provided in English and Spanish based on the needs of the population, and other languages as available or requested (for example, the International Society of Peritoneal Dialysis guidelines on Strategies Regarding COVID-19 in PD). The most popular resource with patients was the "Unhappy with Dialysis" communication tool which was created with the close assistance of the PAC.

In-Center and Home Program Collaboratives

The Network developed an interactive heat map which highlighted home training availability based on monthly data. All were encouraged to utilize the map as a decision tool to support patients to begin home dialysis training at the nearest facility to them, regardless of corporate affiliation. In-center facilities were partnered with nearby home programs to conduct education and improve collaboration. Partners were included in the staff education plan, such as requiring a home RN educator or nephrologist in-service the staff and counsel prospective patients. The Network conducted extensive data collection on barriers and best practices that revealed that many top-performing facilities show reliance on additional teammates that most other facilities do not have access to, such as insurance counselors and RN case managers. Partnership with regional LDO leadership resulted in widespread telehealth adoption by home programs in 2020.

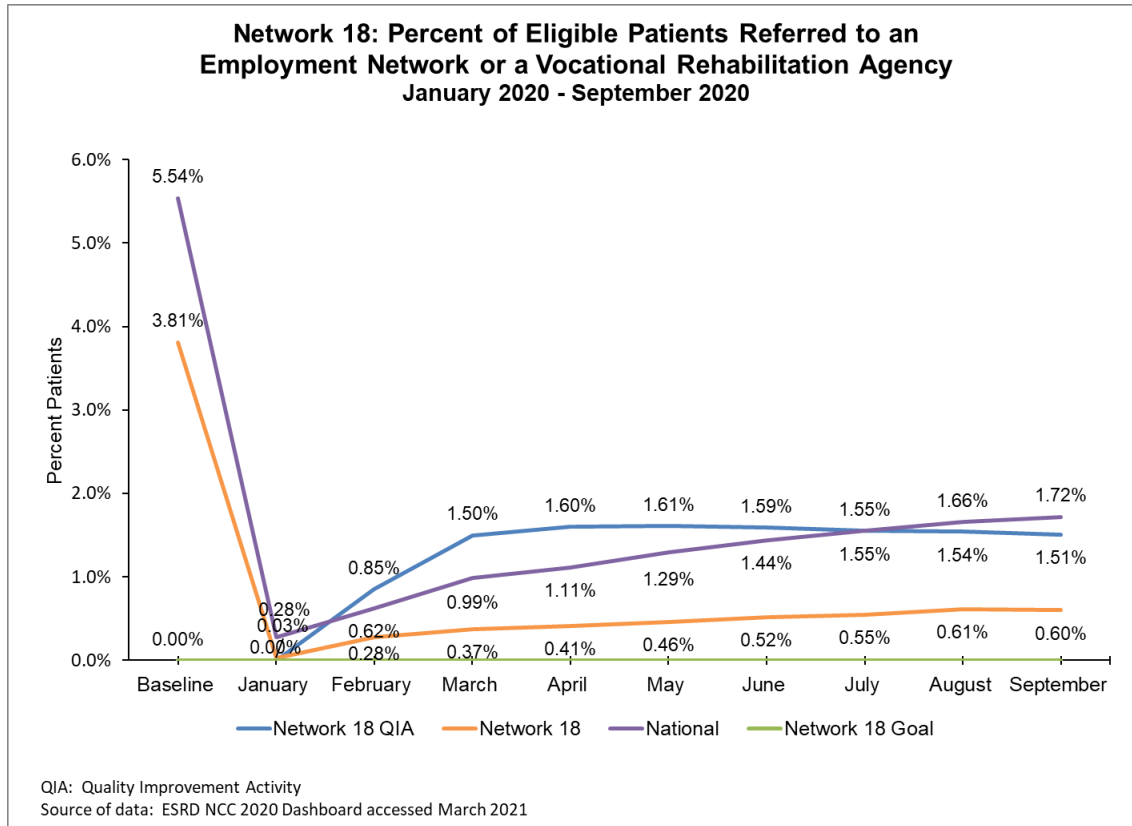
**Network 18: Percent of Patients Starting Home Dialysis
January 2020 - September 2020**



QIA: Quality Improvement Activity
Source of data: ESRD NCC 2020 Dashboard accessed March 2021

Population Health Focus Pilot Project Quality Improvement Activity

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



The Network's PHFPQ project for 2020 focused on supporting gainful employment of ESRD patients (Vocational Rehabilitation or VR). Focusing on 24 facilities representing 10.14% of the Network's patient population, one of which was rural, the project goals were to achieve:

- 50% relative improvement in patients referred to VR
- 1% improvement in patients that were referred becoming active with VR (receiving services)
- 95% of eligible patients screened for VR
- Demonstrate referral of at least 10 eligible patients, between the ages of 55-64, by September 30, 2020

Project Activities:

Facilities were selected for this project and each completed a Root Cause Analysis (RCA) in December 2019. The top improvement needs were 1) Staff comfort with educating on VR, 2) Review of VR in QAPI, and 3) Building relationships with VR counselors. Interventions to aid in improvement in these areas were shared by the Network in a February 2020 VR Kickoff Webinar. Attendees were also oriented on how to navigate the Network's Learning Management System (LMS) to find the VR Resource Library and complete their monthly assignments.

Network 18's focus on 'Putting Patients First: Individual Care Planning' set the stage for facilities to help improve the quality of life for their patients outside of the dialysis clinic. The VR project was designed to:

- Gather information to determine the most effective project interventions and implemented facility processes as a result of learning,
- Promote an interdisciplinary team approach to learning about VR,
- Have patients who become active with VR generate and share their own success stories, and
- Utilize QAPI to demonstrate social work interventions and outcomes.

Focus on Rural Facilities

The Network tracked facility feedback regarding barriers to VR in LMS and compared rural vs. non-rural facility responses.

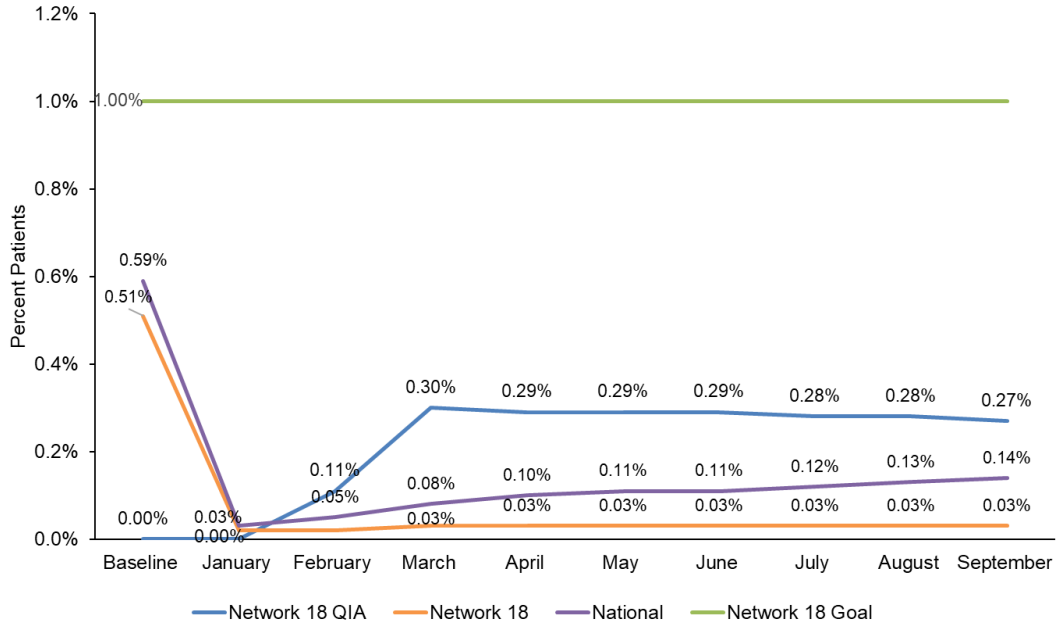
The Network and its' patient advisory council (PAC) developed education for the rural population on Virtual and Work at Home Options. These materials proved to be helpful during the pandemic-related social distancing.

Network VR Activities During COVID-19:

The first known COVID-19 dialysis patient death occurred in late February 2020, and the requirements for this project were suspended. Network 18 continued its' focus on VR throughout the year. Some key activities are listed below:

- Network staff provided VR-related resources and technical assistance to individual staff and patients.
- Social Security Ticket to Work Program webinar announcements were shared with patients and providers.
- Staff published content on VR in a chapter of the ANNA *Core Curriculum for Nephrology Nursing*, Seventh Edition, 2020.
- Staff authored a section on VR in the Forum of ESRD Networks KPAC Transplant Toolkit.
- Staff and a patient representative from the Network's PAC presented on 'Vocational Rehabilitation and Safety at Work During COVID-19' for an August 11, 2020 ESRS NCC Patient Education Webinar.
- Staff and a PAC representative presented to Comagine Health Board members on workplace equity and protections under the Americans with Disabilities Act, and the role of VR in helping to reduce or eliminate workplace barriers to perform essential job functions (work accommodations).

**Network 18: Percent of Referred Patients Receiving Services from an
Employment Network or Vocational Rehabilitation Agency
January 2020 - September 2020**



QIA: Quality Improvement Activity
Source of data: ESRD NCC 2020 Dashboard accessed March 2021

ESRD NETWORK RECOMMENDATIONS

ESRD Network 18 did not recommend any sanctions in 2020. While we referred cases/facilities to the state agency for state survey for follow up we did not recommend any sanctions.

Network 18 had one transplant facility and seven dialysis facilities permanently close in 2020. The Network service area would be better served by increasing the number of facilities with nocturnal dialysis shifts, home hemodialysis program and potentially taking higher acuity level patients (for example stable long-term tracheotomy patients). These recommended programs would increase patient choice and allow more flexibility to nephrologist to individualize the type of dialysis treatment to best meet the patients' needs.

ESRD NETWORK COVID-19 EMERGENCY PREPAREDNESS INTERVENTION

Network 18's sister Network was notified via phone message from a dialysis provider of a patient that had passed due to COVID-19 on March 01, 2020. Network leadership team met and discussed reliable information and decided on a timeline and method of distribution of information/guidance. The first information/guidance on COVID-19 was distributed to dialysis providers on March 02, 2020. Network staff joined state, county and Health and Human Services/Centers for Disease Control (CDC) list serves and monitored guidance to communicate to dialysis providers and dialysis/kidney transplant patients. Updated contact list for EOC/ESF8, local coalitions and other local/national resources were updated and distributed.

The Network used several methods to communicate guidance to the dialysis providers and kidney transplant/dialysis patients including:

1. Weekly/ad hoc COVID-19 email updates to dialysis providers
2. COVID-19 Q&A webinars for providers with patients invited
3. Network Blog- provider, community and patient members
4. Emails to patient SMEs and Patient Advisory Council
5. COVID-19 Helpline (started April 1st) and phone/email responses
6. ESRD Learning Management System- resources highlighted and on demand
7. COVID-19 resources section added to the Network website

By March 09, 2020 the Network 18 website had links to important resources and information for dialysis providers and kidney transplant/dialysis patients that was updated throughout the year.

A COVID-19 helpline and targeted technical assistance were used to assist providers and patients with information and issue surrounding COVID-19. All staff were cross-trained to support the pandemic response and an internal Helpline Guide served as a fluid resource for on-call staff to answer questions and refer to the appropriate and up-to-date guidance. Helpline/targeted assistance topics varied widely over the year to include basic information and guidance, transportation issues, supply issues, staffing issues, masking requirements, guidance on return to work and removal from isolation precautions post COVID-19 or COVID-19 exposure, becoming a vaccination provider, vaccination information, etc.. We partnered with our State Survey Agencies to get emergency approval for facilities and extra stations for COVID-19 cohorts.

Due to the infection nature of COVID-19, the Network required all dialysis providers to perform the CDC hand hygiene and dialysis station disinfection tools, as well as the hand sanitizer audit tool when it was available, monthly. The Network analyzed the missed opportunities and developed education to improve infection control. Starting in May 2020, the Network started to discuss the potential of dialysis providers becoming COVID-19 vaccine providers with the dialysis companies and state/county departments of health.

Network 18 contributed to new interventions/tools for COVID-19 in various methods including:

1. Developed COVID-19 Fatigue Screening Tool for both providers and patients
2. Contribute to and Medical Review Board/Board of Directors input to the NCC Hand Sanitizer Tool
3. Developing a Mental Health Guide
4. Contributing to the COVID-19 vaccination toolkit
5. Developing a resource to help medical providers prepare/be comfortable with telehealth visits - Tele-Etiquette for Providers
6. PAC developed a tool to discuss dialysis modality with their doctor
7. Collaborated with Medical Education Institute on a blog "Dialysis Travel During the COVID-19 Pandemic"

ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION

In addition to managing a pandemic, the Network experienced a historic wildfire season, events of civil unrest, and power outages.

During the 2020 fire season, the Network monitored and responded to an unprecedented number of large wildfires. The Network used the ArcGIS mapping software to monitor and track weather conditions, identify and distribute warnings and evacuation information to clinics, and LDO leadership. The Network contacted at risk facilities directly and offered technical assistance, support, and information.

The use of innovative mapping technology proved beneficial as an early warning system for the Network and facilities. The Network was able to identify fire locations and notify at risk facilities early enough to activate their internal emergency plans and respond appropriately. The Network continued to provide supplemental support for displaced patients and assistance to facilities in coordinating alternative treatment locations.

Additionally, the Network tracked evacuations of facilities treating COVID-19 patients.

The Network conducted safety outreach calls daily to facilities in the impacted regions of wildfires. This process was successful with catching and mitigating challenges arising due to a significant number of patient and staff evacuations and displacements experienced as a result of the Silverado fire. Network and facilities reported smooth coordination of care with back up facilities and local emergency response organizations as a result of the advance notice provided by the Network.

Training and Education Provided:

The Network developed and provided education and training to facilities, including an overview of the ICS/NIMS emergency response infrastructure, use of a newly developed comprehensive disaster contact list, education on the process of disconnecting from dialysis in the event of an emergency, and reporting of emergency events or facility interruptions in service to the Network. Similarly, the Network shared updates on any CMS Emergency Preparedness Testing Exercise Requirements and KCER resources such as the "How to Complete an After-Action Report" training.

The Network served as liaison between emergency operations centers, healthcare coalitions and dialysis providers. The Network successfully collaborated with LA County, Powered for Pts and Southern California Edison regarding emergency preparedness and timely notification of power outages. The Network maintained 100% participation and attendance at all KCER Meetings including attending the KCER summit in Baltimore with a Patient SME.

Summary of significant events:

6/20- The Network notified all facilities regarding riots and provided instructions regarding the completion of Facility Interruption in Service Form. Four facilities closed as a precautionary measure due

to rioting. All impacted patients were rescheduled, clinics reported no damage, and were able to resume normal operations the following day.

8/20- Two clinics experienced closures lasting less than 24 hours. The Network monitored three wildfires and contacted nearest facilities. No impacts reported.

9/20-Two clinics were impacted by local fires. One was evacuated due to a power outage and re-opened following day. The other evacuated due to toxic smoke and re-opened several days later. An ESSR was submitted.

10/20-The Network experienced 3 large wildfires in the month of October. The Silverado fire being the largest. Several facilities reported minor disruptions to services due to power outages which were restored the within 48 hours. KCER and CMS notified.

11/20-Local fires were monitored for facility/patient impact. 10 emergency events were reported to the Network resulting from power outages, water treatment system failures and staffing.

12/20- Facilities reported a total of 12 emergency events resulting from equipment malfunctions, minor flooding/water damage, and power outages. An ESSR was submitted.

ACRONYMLIST 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.