

## **Kidney Community Emergency Response (KCER) Coalition: Partnering to Improve Preparedness and Outcomes in Disasters**

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*Emergency events that could occur nationwide and affect the renal community include earthquakes, fires, floods, blizzards, hurricanes, tornados, ice storms, chemical spills, pandemic disease and acts of terror. Each emergency has the potential to affect access to care. Facilities should be prepared to address concerns such as lack of power, water, food, housing and communications; dangerous conditions; flooding; fuel shortages; patient tracking issues; mass zone evacuations; rapidly changing weather; road closures and patient transportation issues; curfews; hospital closures and limited staff resources. Providers should be prepared to assist patients with little or no notice. The Kidney Community Emergency Response Coalition is working together to minimize disruption to life-sustaining dialysis and transplant services in emergencies.*

### **INTRODUCTION**

The Kidney Community Emergency Response (KCER) Coalition is represented by patient and professional organizations; practitioners; providers, including independent dialysis facilities, large dialysis organizations and transplant facilities; hospitals; suppliers; end-stage renal disease (ESRD) networks; state emergency and survey representatives; and federal agencies. These organizations are committed to assisting state and local responders in meeting the life-saving medical needs of individuals with kidney failure under all circumstances. Through the collaborative efforts of the KCER partners, the goals of the coalition are to:

- raise public awareness of the critical needs of individuals with kidney failure, the providers that service them, and the need to plan ahead to ensure life-saving services are available/obtainable
- promote and disseminate tools and resources for individuals with kidney failure, dialysis facilities, transplant facilities and key partners in emergency response at the federal, state and local level
- plan for a possible flu pandemic
- test and refine a national response strategy to assist federal, state and local efforts in the event of an emergency and/or disaster.

KCER's activities, in partnership with Centers for Medicare & Medicaid Services (CMS), have contributed toward significant changes in regulatory require-

ments, including proposed new emergency preparedness and response language in the ESRD Conditions of Coverage, which are under revision with an early 2008 target date for final rule publication. Additionally, the new ESRD Network contract includes clear requirements for every Network to have in place plans for disaster response. This article provides a review of the history of the formation and development of KCER, information on the coalition's continued efforts toward improved processes and a discussion about how social workers can be a part of the emergency response and help save lives in the kidney community.

### **BACKGROUND: KCER PHASE I**

The severity of the 2004 Florida hurricane season and the effect it had on the Florida renal community was unexpected and unprecedented. Four hurricanes—Charley, Frances, Ivan and Jeanne—affected Florida, making it the only state since 1886 to sustain the impact of four hurricanes in one season. These four hurricanes made landfall in the state within 45 days and caused a large portion of the dialysis community to be unable to function normally. Hurricane Charley made landfall on August 13 as a category 4 hurricane just north of Captiva, FL, struck the city of Punta Gorda and neighboring Port Charlotte with devastating results, continued across the Florida peninsula and exited the state at Daytona Beach. Charley came ashore again near

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Cape Romain, SC, on September 14 as a weakening hurricane, moved just offshore, made landfall at North Myrtle Beach, SC, then weakened to a tropical storm over southeastern North Carolina. Approximately 90 Florida facilities were in the path of Charley; 25 were left without power and/or water and another 4 facilities had significant damage. Patients from the downed facilities were redirected to other local dialysis centers for treatment and two dialysis units were approved for addition to dialysis stations to accommodate displaced patients.

Hurricane Frances hit Florida on September 4. Because of the size and the predicted path, practically the entire state was at risk. The CMS Atlanta Regional Office established a response team to assist providers with any questions regarding the billing process for patients who might be receiving services temporarily in a facility due to the hurricane. The Agency for Healthcare Administration (state agency) coordinated preparedness and response efforts with FMQAI: The Florida ESRD Network (Network 7). Based on lessons learned from Charley, off-site contact numbers and alternate e-mail addresses were shared among Network staff, state agencies, emergency responders and providers to facilitate after-hours contact and/or contact with individuals who may have been evacuated from their usual office/facility location. When the storm was approaching, Florida providers dialyzed patients, with many of the facilities providing treatments throughout the night. Due to the slow forward motion of Frances, facilities were planning to be closed for at least 2 days. Frances made landfall as a category 2 hurricane over the southern end of Hutchinson Island, FL. Frances moved slowly across the Florida Peninsula, emerged into the northeastern Gulf of Mexico near New Port Richey, then made landfall again in the Big Bend region of Florida. Frances headed northeast over eastern Alabama and western Georgia, weakened, and continued over West Virginia, across New York and northern New England with gale-force winds. In Florida, 84 units lost power, water or both due to Frances. Many patients did not receive treatment for 2 to 3 days, and because of the limited number of functioning facilities, patients were triaged and dialyzed based on need. Very few units were able to open along the Florida's east coast, from Melbourne south to West Palm Beach. Two facilities received major damage forcing them to close indefinitely: a north Florida facility with sinkholes surrounding the unit and another in southwest Florida that had its new roof (repaired from Charley) torn off.

Hurricane Ivan made landfall just west of Gulf Shores, AL, on September 16 as a category 3 hurricane, and resulted in strong winds over a narrow area near the southern Alabama-western Florida panhandle border. After Ivan moved across the barrier islands of Alabama, it crossed Mobile Bay and into central Alabama. Ivan continued over the northeast, causing flash floods and tornado damage across much of the southeastern United States. Ivan looped back and crossed the southern Florida peninsula from the Atlantic and then the Gulf of Mexico on September 21, then crossed Mississippi and southwestern Louisiana as a tropical depression, finally dissipating over the upper Texas coastal area on September 24.

The Florida ESRD Network began monitoring reports from the Emergency Operations Center related to Hurricane Ivan less than 1 week following Frances. Although facilities were still recovering from Hurricane Frances, Network 7 hosted a preparedness conference call, with 170 Florida providers participating. Three facilities affected by Hurricanes Charley and Frances shared lessons learned and best practices. A Special Open-Door Forum was also arranged and hosted by CMS to discuss the significant hurricane relief efforts in Florida, how to make a difficult situation as uncomplicated as possible and plan for continued quality care for kidney patients during and after the storm. As Ivan's uncertain track left the entire Gulf Coast in harm's way, Network 7, at the request of CMS, conducted a "Best Practices/Lessons Learned" session with ESRD Networks 6, 8, 13 and 14. CMS and state agencies for each of the states that might be affected were also on the call.

When Ivan hit Florida on September 21, it remained on land for more than 12 hours. Eleven Florida facilities reported being unable to operate due to Ivan. ESRD Networks 6 and 8 partnered with Network 7 to help patients and facilities by identifying units that were open for treatment. One facility requested that water be brought to them to dialyze patients. A nonaffiliated corporate group assisted the facility by sharing a water tanker truck they had on stand-by. A guide for water treatment during a "Boil Water Alert" was distributed to the affected providers as a resource.

Hurricane Jeanne appeared as a threat to the east coast of Florida within a week of Ivan. Jeanne made landfall on the east coast of Florida on September 26 as a category 3 hurricane, moved across central Florida, then northward across central Georgia, the Carolinas, Virginia and the Delmarva Peninsula. In the aftermath of Jeanne, an

initial status check found 45 Florida facilities without power and/or water or damaged. Five of these facilities had been damaged from previous 2004 hurricanes.

In response to lessons learned in 2004, CMS awarded Network 7 a special study: “Developing Strategies and Strategic Partnerships to Overcome Disasters.” The purpose of this study was to help other ESRD Networks in their disaster planning for patients, providers and stakeholders. Activities conducted included:

- development of a best-practice checklist for use by ESRD Networks
- a mock disaster drill with the expectation that all ESRD Networks respond as they would in a real disaster
- a disaster-readiness survey distributed to all Networks, to assess and measure their perceived emergency preparedness level.

Hurricane Katrina hit in the early stages of the study, and led to expansion of the scope of the project. Katrina caused damage on August 25, 2005 in southern Florida as a category 1 hurricane, emerged into the southeastern Gulf of Mexico, gained strength to a category 5 hurricane, turned northward toward the northern Gulf Coast, around the ridge over Florida, then made landfall as a category 3 near Buras, LA, on August 29. Katrina continued northward and made its final landfall near the mouth of the Pearl River at the Louisiana/Mississippi border. Katrina weakened rapidly after moving inland over southern and central Mississippi, becoming a category 1 hurricane. It weakened to a tropical storm just northwest of Meridian, MS, before moving over the southeastern United States, the Tennessee Valley and the Great Lakes. In anticipation of Katrina, ESRD Networks 7, 8, 13 and 14 contacted providers and reminded them to implement their emergency plans. Emergency contact numbers were sent to providers along with reminders to advise the Networks of any damage or assistance needed. Patients were dialyzed in advance of the hurricane’s predicted landfall. Pre-landfall in Louisiana, CMS, Network 7, the American Nephrology Nurses Association and the National Renal Administrators Association planned strategies to assist affected Networks with coordination of staffing needs/volunteers, patient tracking, exchange of key medical records and identifying/listing facilities as open or closed. When Katrina hit on August 29, it affected the operation of 94 facilities, (9 in Alabama, 31 in Mississippi and 54 in Louisiana). Approximately 5,849 dialysis patients were in the affected areas. Katrina also impacted accessibility to renal transplant care (transplantation, access to anti-rejection medications and physician follow-up, etc.). Network 8’s office in Jackson, MS, lost power, telephone service and Wide

Area Network capability for 4 days, moving to an alternate location to conduct response efforts. The majority of patients—more than 600 dialysis patients—fled to Texas.

Network 14, which serves Texas, was assisting Katrina evacuees while under the threat of Hurricane Rita, which struck near the Texas/Louisiana border as a category 3 hurricane on September 24. Rita produced significant storm surges that devastated coastal communities in southwestern Louisiana, and its winds, rain and tornadoes caused fatalities and a wide swath of damage from eastern Texas to Alabama. Additionally, Rita caused floods due to storm surge in portions of the Florida Keys. Assisting displaced patients was difficult, as many had multiple relocations because of evacuation route and shelter changes. Locating shelters close to available dialysis services posed a challenge. An even bigger challenge was the task of arranging and coordinating transportation. ESRD Networks 7, 8, 13 and 14 assisted patients in locating facilities and resources and served as a communication conduit for the renal community and state, federal and local emergency workers. Industry stepped in to assist with supplies. The National Kidney Foundation (NKF) established a listserv for the kidney community and key partners, and Network 13 hosted daily community-wide conference calls. The renal community learned important lessons from Hurricanes Katrina and Rita, and it was imperative to include these efforts as part of the project. Plans for a National Disaster Summit began.

The National Disaster Summit convened on January 19, 2006 in Washington, D.C., to review disaster response in the ESRD community, plan for the future and explore interest in the formation of a national coalition. Eighty participants—residents of 25 states and the District of Columbia—shared in planning for national strategic responses and priority action areas. Participants decided to form a national coalition, later named the KCER Coalition. Eight response teams were established to address patient assistance, volunteer coordination, physician assistance, communications, patient and facility tracking, facility operations, federal response and industry supplies/services. A Strategic Planning Committee was formed with representatives from each response team. Phase I of the KCER included the development and initial dissemination of tools and resources to help patients, facilities, emergency responders and coalition members plan for and respond to emergencies and disasters. The NKF was the administrative lead responsible for coordinating Coalition activities during Phase I.

## KCER PHASE II

Network 7 assumed the lead for administrative support of the KCER in Phase II and convened the second KCER Summit on March 1, 2007 in Baltimore, MD. There were 120 Summit participants, residing in 32 states. ESRD Networks 2, 12, 13, 14 and 17 shared lessons learned from 2006 regional disaster experiences (snowstorms, sudden wind storms, ice storms, a facility fire, tornadoes and severe flooding), with emphasis on all hazards. Network 7 led a tabletop mock disaster drill to test kidney community response mechanisms and aid in planning for Phase II activities. The drill aided the response teams in identifying issues, priorities and gaps in response mechanisms. Some areas of improvement identified included: further definition of KCER roles and processes in emergency response; continued work with the National Disaster Medical System to develop a federal response capacity to provide nephrology staff for emergency events; strengthened processes of communication/coordination with state agencies, ESRD Networks and CMS regional offices; and opportunities for further education for community partners, such as special needs shelters. A ninth team, the Pandemic Preparedness Response Team, was established, whose goal is to develop and disseminate plans to help the kidney community maintain its ability to care for patients in the event of pandemic flu. One major challenge in the ESRD population with pandemic flu is that patients who depend on in-center hemodialysis cannot just stay home. The Pandemic Preparedness Team will work with federal, state and local agencies to assure coordination with KCER planning. The Summit ended with a roll-out of the new Web site ([www.KCERCoalition.com](http://www.KCERCoalition.com)), which has KCER emergency contact information and links to key resources and organizations involved in preparedness and response for the kidney community. Activities of the 9 response teams are posted on the Web site. Briefly, the response team focus areas are:

- patient assistance: education of patients on preparedness and coordination of financial aid when needed and available
- communication: toll-free helpline, e-mail listserv and conference calls during emergencies
- facility and patient tracking: tracking of displaced patients and reporting on facility open/closed status
- federal response: education of federal agencies and state partners and direct federal resources during a disaster response
- staff and volunteers coordination: maintenance of a database of emergency/disaster volunteers and education on deployment

- industry supplies and services: assistance with plans for emergency distribution of dialysis and transplant supplies
- physician placement and assistance: facilitation of the provision of nephrology expertise for management of dialysis and transplant patients during a large-scale crisis
- pandemic preparedness: collaborate with federal/state agencies to coordinate ESRD services in the event of a major pandemic
- facility operations: assistance of facilities with preparedness and response

## THE SOCIAL WORKER'S ROLE IN PLANNING, RESPONSE AND IMPROVING OUTCOMES

Medicare ESRD Conditions for Coverage require that social services are provided to patients and their families and are directed at supporting and maximizing the social functioning and adjustment of the patient. This includes: conducting psychosocial evaluations; participating in team review of patient progress and recommending changes in treatment based on the patient's current psychosocial needs; providing casework and group work services to patients and their families in dealing with the special problems associated with ESRD; and identifying community social agencies and other resources and assisting patients/families in their utilization of them. Social workers have the opportunity in their role to significantly impact patient and family emergency preparedness. Medicare regulations require facilities to have written disaster policies and procedures in place, train all personnel in their roles in emergencies and fully inform patients regarding where to go, what to do and who to contact. Social workers are required to assist at the provider level by knowing and following the facility's emergency preparedness policies and procedures. Social workers can provide support to patients and their loved ones in their emotional adjustment to emergency events. Identification of community social agencies/resources and education are important components to being prepared, not just when emergencies occur, but throughout the year. Emphasis should be placed on year-round preparedness education. An important component of this education is to empower patients to know their plan. Ask patients specific questions about their plan, such as how they will communicate or what is their back-up plan for transportation. Advise that dialysis services may not be available for days when emergencies occur, so patients should have their current flow sheets, treatment orders, emergency diet instructions, communication plan and lists of facilities and emergency contacts on hand. Assistance should be offered to patients and their loved ones with resource utilization.

Emergencies can happen with little or no notice, and each partner from the kidney community plays a critical role in the event of a disaster. The work of the KCER requires a coordinated, comprehensive and continuous effort from the entire renal community, not just the coalition. In addition to assisting patients and their loved ones, social workers can:

- work within the local community to coordinate planning, including local ESRD Networks, emergency management offices, hospitals and other key responders
- participate in local, state and national coalitions and assist with ongoing coalition development
- assist staff with developing a personal disaster plan
- emphasize year-round preparedness and an all-hazards approach
- conduct practice drills with patients and staff
- continually critique processes.

Social workers should be committed to continued examination of their facility's preparedness level and in improving disaster response performance. With each emergency situation, learning occurs quickly and can be applied to the next event. Conduct continuous quality improvement activities after emergency events to identify lessons learned and improvement

opportunities. These efforts can improve quality care and access to treatment for the kidney community, especially during emergencies.

### **SAMPLE QUALITY IMPROVEMENT PLAN (QIP)**

The Florida Kidney Disaster Coalition developed an Emergency/Disaster Review QIP, which can be used to conduct facility in-services or presented or reviewed at monthly quality meetings. Using this tool is an excellent way to demonstrate to Medicare and state survey agencies that a facility is addressing disaster preparedness. The QIP template can be used to review and track improvement in processes based on identified areas of need. Most concerns or challenges faced in disaster preparedness and response can be tracked and measured at the facility level. A sample QIP that addresses the critical role of the renal social worker in the coordination of care in emergency planning for nursing home patients is provided for reference (see Appendix A). A link to download this tool, as well as other resources developed by the KCER, ESRD Networks and their local coalitions is available at [www.KCERCoalition.com](http://www.KCERCoalition.com) JNSW

