

Network 8, Inc.

# **2004 ANNUAL REPORT**

Activities performed under this contract were sponsored  
by the Centers for Medicare & Medicaid Services  
CMS Contract Number 500-03-NW08

July 1, 2005

## **Preface**

This year's report includes an emphasis on activities undertaken to stimulate improvement in our region's AV fistula rates, which remain among the lowest in the nation. Our efforts have been broad-based in recognition of the fact that dialysis facility staff and nephrologists exercise only partial influence over fistula creation rates. It has been instructive to work with nephrologists, facility staff, and patients to gain a better understanding of the challenges faced at every step of the way.

This report also includes a reference to the ESRD Outpatient Medications Project, a special project we undertook with CMS. An important foundation was laid in systematically identifying medications that most experts believe should always be avoided as well as those that should always be available as therapeutic tools for Stage 5 CKD patients. We were privileged to work both with a top-tier panel of national experts from the fields of pharmacy and nephrology and with our partners at the University of Mississippi School of Pharmacy, whose technical guidance was critical to the project's success.

As always, we recognize with appreciation the day-to-day contributions of those whose daily work with CKD patients underpins our efforts to promote better outcomes for those we serve.

Philip W. Rogers, M.D., Chairman  
Board of Directors

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## **Introduction**

This publication presents an overview of activities conducted under the Centers for Medicare & Medicaid Services (CMS) contract in CY 2004 for the ESRD program in Alabama, Mississippi, and Tennessee.

The ESRD program was created by Congress (Public Law 92-603) in October 1972. With this legislation, Medicare eligibility was extended to almost all citizens with ESRD, regardless of age. The law provided payment from Medicare trust funds to reimburse the cost of dialysis and transplantation performed by approved providers.

Within four years, the Network program was implemented with goals of promoting quality of care, improving cost effectiveness, and monitoring access to care. Initially there were 32 Network regions organized around regional delivery of care patterns. Since that time, the role of Networks has evolved to focus less on resource allocation and more on quality improvement and information management. As a result of subsequent legislation, there are now 18 Network regions of varying geographic size but with roughly equivalent ESRD populations.

CMS contractual goals for ESRD Networks include the following:

- Improve the quality of health care services and quality of life for ESRD beneficiaries
- Improve data reliability, validity, and reporting among ESRD providers/facilities, Networks, and CMS
- Establish and improve partnerships and cooperative activities among and between the ESRD Networks, Quality Improvement Organizations (QIOs), State survey agencies, ESRD providers/facilities, ESRD facility owners, professional groups, and patient organizations.

The activities undertaken to advance these goals are summarized in this report.

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**I. Network Description**

The Network 8 geographic region includes the states of Alabama, Mississippi and Tennessee, covering 50,750, 46,914, and 41,220 square miles respectively (138,884 square miles total). There exists substantial cultural and economic diversity from state to state and within the states. Population data in the following two tables were taken from the 2000 US Census.

**State Profile by Race, Number and Percent, All Ages**

Subject	Alabama		Mississippi		Tennessee	
	Number	Percent	Number	Percent	Number	Percent
<b>Race</b>						
Total population	4,447,100	100.0	2,844,658	100.0	5,689,283	100.0
White	3,162,808	71.1	1,746,099	61.4	4,563,310	80.2
Black or African American	1,155,930	26.0	1,033,809	36.3	932,809	16.4
American Indian/Alaska native	22,430	0.5	11,652	0.4	15,152	0.3
Asian	31,346	0.7	18,626	0.7	56,662	1.0
Hawaiian, Pacific Islander	1,409	0.0	667	0.0	2,205	0.0
Other Race	28,998	0.7	13,784	0.5	56,036	1.0
Two or more races	44,179	1.0	20,021	0.7	63,109	1.1
<b>Hispanic/Latino</b>						
Total population	4,447,100	100.0	2,844,658	100.0	5,689,283	100.0
Hispanic (any race)	75,830	1.7	39,569	1.4	123,838	2.2
Non-Hispanic	4,371,270	98.3	2,805,089	98.6	5,565,445	97.8

Source: U.S. Census Bureau, Census 2000 Redistricting Data Summary File

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**State Profile by Race, All ages and 18 Years and Over**

Subject	Alabama		Mississippi		Tennessee	
	All ages	18 and over	All ages	18 and over	All ages	18 and over
<b>Race</b>						
Total population	4,447,100	3,323,678	2,844,658	2,069,471	5,689,283	4,290,762
White	3,162,808	2,440,176	1,746,099	1,340,870	4,563,310	3,524,497
Black or African American	1,155,930	796,342	1,033,809	658,259	932,809	636,300
American Indian/Alaska native	22,430	16,144	11,652	7,629	15,152	11,530
Asian	31,346	23,724	18,626	13,604	56,662	42,365
Hawaiian, Pacific Islander	1,409	1,063	667	494	2,205	1,597
Other Race	28,998	18,977	13,784	9,575	56,036	38,188
Two or more races	44,179	27,252	20,021	12,040	63,109	36,285
<b>Hispanic/Latino</b>						
Total population	4,447,100	3,323,678	2,844,658	2,069,471	5,689,283	4,290,762
Hispanic (any race)	75,830	50,955	39,569	27,509	123,838	84,939
Non-Hispanic	4,371,270	3,272,723	2,805,089	2,041,962	5,565,445	4,205,823

Source: U.S. Census Bureau, Census 2000 Redistricting Data Summary File

## **II. Network Structure**

### **A. Full-time Network Personnel with Key Responsibilities**

- Jerry Fuller, Executive Director (ED), administers the contract, supervises key staff, and serves as primary liaison to Network Board of Directors.
- Sylvia Catchings, Office Manager (OM), performs payroll and bookkeeping duties, provides primary audit support, coordinates employee benefits, and provides other administrative and office management support.
- Ann Pridgen, RN, Quality Improvement Director (QID), oversees and implements QI activities and projects, directs the activities of the QIC and QI assistant, edits the facility newsletter, and assists in the development and implementation of Network educational workshops.
- Sheila Mitchell, MSN, ACNP, CNN, Quality Improvement Coordinator (QIC), serves as liaison to the Medical Review Board and provides day-to-day technical assistance to ESRD providers. She served as clinical coordinator of the CMS-funded ESRD Outpatient Medications Project.
- Brenda Dyson, Patient Services Coordinator (PSC), serves as the primary contact for the patient grievance process, produces the quarterly patient newsletter, coordinates patient education, and serves as liaison with allied state and national renal patient organizations. She assists on a variety of information clearinghouse tasks, including clinical performance measures (CPM), Dialysis Facility Reports, disaster preparedness, and others.
- Judy Carter, Information Systems Director (ISD), manages the data department, supervising three data specialists. She is responsible for the accuracy and completeness of the patient tracking system (SIMS), coordination of VISION training, filling of data requests, and provision of cross departmental IS support.
- Janet Henn, Data Specialist (DS), enters and validates data from CMS and Network forms for the state of Tennessee and performs other data reconciliation functions.

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- April Freeman, Data Specialist, enters and validates data from CMS and Network forms for the state of Mississippi, and provides backup mail handling for the office manager.
- Katie Wilcher, Data Specialist, enters and validates data from CMS and Network forms for the state of Alabama, processes returned new patient packets, and manages weekly offsite storage of backup tapes.
- Cathy Thornton-Hartzog, MHS, BSN, RN, CHN, CNN, Education Programs Consultant, assists with program development and implementation for meetings such as the annual education symposium and council meeting.

**B. Committees**

**Board of Directors**

The Board of Directors sets policy, establishes and manages the Network's financial operations, and directs the administrative staff in performance of contract requirements. The Board is composed of fifteen members and convenes four times yearly, twice in person and twice by teleconference. The Board develops and/or approves policies and procedures, administers affairs of the Network Council (an advisory body representing all regional ESRD providers), and appoints the Medical Review Board.

<b>Board of Directors as of December 31, 2004</b>	
Philip W. Rogers, MD, Chairman Hattiesburg, MS	Cathy Folk, MA, RD, CSR, LDN Nashville, TN
Kent Taylor, MD, Vice-Chairman Selma, AL	Tom Ozbirn, DO Birmingham, AL
Angie Kurosaka, RN, CNN, Secretary-Treasurer Birmingham, AL	Ellen Predmore, MSW, LCSW Chattanooga, TN
Alp Ikizler, MD Nashville, TN	Ellie Durrett, Patient Representative Nashville, TN
Cynthia Powers, BSN, RN, CNN, Network Council Chairman Memphis, TN	Martin Lee, MD Tupelo, MS
Renay Sykes, RN, CNN Grenada, MS	Keith Johnson, MD Nashville, TN
Carol Headley, DNSc, RN, CNN Memphis, TN	Douglas Lanier, MD Gulfport, MS
	Jerry Jackson, MD, ex officio MRB Chairman Birmingham, AL  John D. Bower, MD, ex officio Financial Officer Jackson, MS

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**Medical Review Board (MRB)**

The MRB is similar in composition to the Board of Directors. Among its principal objectives are developing and implementing quality improvement initiatives and evaluating facility and patient concerns and complaints. The MRB oversees the Network's quality initiatives with guidance from the CMS central and regional offices (RO) and with technical direction from CMS government task leaders. On-site investigations occasionally are undertaken by the MRB or by staff under MRB direction.

<b>Medical Review Board as of December 31, 2004</b>	
Jerry Jackson, MD, Chairman Birmingham, AL	Tom Wooldridge, MD Tupelo, MS
Suzanne Bergman, MD, Vice Chairman Birmingham, AL	Kirit Joshi, MD Dothan, AL
Mahmoud Salem, MD Jackson, MS	Connie Andrews, MSN, CNN, NP-CRN Mobile, AL
Karen Bush, MSW Montgomery, AL	Gerald Schulman, MD Nashville, TN
Phyllis Egbert, MSN, RNC, ACNP, CNN Nashville, TN	Alice Watson, MS, RD LD Columbus, MS
A. Randle White, MD Greenwood, MS	Santiago Vera, MD Memphis, TN
Ruth Crenshaw-Love, RN Patient Representative Montgomery, AL	

**Network Council**

The Network Council consists of one health professional representative appointed by each transplant and dialysis facility. Additionally, the patient advisory council chairman from each state serves on the Council. Council members nominate those serving on the Board of Directors and Medical Review Board.

Council officers are Chairman, Vice-Chairman, and Secretary. Officers may serve up to three consecutive two-year terms, and they meet throughout the year in person or by telephone to conduct business and to plan for the annual meeting. The Chairman represents the Council on the Network 8 Board of Directors as a full voting member.

The full Council meets annually and has an opportunity to network with professional peers, participate in educational offerings, and give input to the staff and Network Board on provider issues and concerns.

The following officers serve from 2003-2005.

<b>Network Council Officers</b>		
Chairman	Cynthia Powers, RN, CNN	Tennessee
Vice-Chairman	Cynthia Frazier, RN, CNN	Alabama
Secretary	Barbara Walker, RN	Mississippi

**Patient Advisory Council**

Each facility in the Network designates a patient representative to serve on the state-specific Patient Advisory Council (PAC). An annual educational meeting is held in each state on a range of current ESRD topics focused on health and quality of life issues. The meeting also serves to keep patients abreast of CMS and Network goals and to allow them an opportunity to comment on the strategies employed to achieve them. The Chairman of each PAC is an ex-officio member of the Network Council.

<b>Patient Advisory Council Officers</b>		
Chairman	Michael Tharpe	Alabama
Chairman	Delorse Craft	Mississippi
Chairman	Ezell Gardner	Tennessee

**Transplant Advisory Committee**

The Transplant Advisory Committee (TAC) is a subcommittee of the MRB, and the MRB transplant surgeon serves as committee chairman. Activities may include review of relevant transplant data, advisory services to the MRB on access to care issues, and ad hoc liaison for the resolution of transplant related problems within the Network. The following members served on the committee as of December 31, 2004.

<b>Transplant Advisory Committee Members</b>		
Chairman	Santiago Vera, MD	Tennessee
Member	Shirley Schlessenger, MD	Mississippi
Member	Martha Tankersley, RN, MSN	Alabama
Member	Lucius Wright, MD	Tennessee
Member	Velma Scantlebury, M.D.	Alabama

## **CMS Goals and Network Activities**

### **I. Improving the Quality of Health Care Services and Quality of Life For ESRD Beneficiaries**

#### **Fistula First: The National Vascular Access Improvement Initiative**

##### **Project Background**

Fistula First: the National Vascular Access Improvement Initiative, a CMS directive, continued as the primary quality improvement project of the ESRD Networks throughout 2004. The Institute for Healthcare Improvement (IHI) remained a key partner and project consultant to CMS and the Networks. As project lead for the states of Alabama, Mississippi and Tennessee, Network 8, Inc. continued to promote project awareness and provide educational opportunities and resources to encourage practices proven to improve vascular access outcomes.

The Fistula First project, introduced in July 2003, resulted from an increased incidence of hemodialysis vascular access complications, leading to increased hospitalizations, costs, morbidity, and mortality. These problems were attributed to increased use of arteriovenous grafts (AVG) and central venous catheters (CVC) and decreased use of arteriovenous fistulas (AVF).

The project goals of improved vascular access outcomes, to be achieved by promoting increased use of the AVF, were designed to reflect the K/DOQI practice guidelines for AVF use in incident and prevalent patients. The CMS national goal of 40% AVF use in prevalent patients is to be achieved by 2006. Along with the national goal, CMS assigned each ESRD Network an individual target goal for improvement in AVF prevalence rates. As the baseline Network 8 AVF prevalence rate of 26.3% (2002 CDC data) fell well below the national rate of 32.4% and prevalence goal of 40%, Network 8 was assigned a 5% target rate of improvement.

##### **Project Set-up and Promotion**

Much of the 2003 and early 2004 Fistula First activities were focused on project set-up to include data collection, strategic planning and project promotion to dialysis providers, surgeons, interventionalists, patients and others in the healthcare community.

Monthly electronic data transmission from large dialysis organizations (LDOs) began in September 2003 and manual data submission from Network 8

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independent facilities began in January 2004. A group of LDO facilities, unable to transmit data electronically, voluntarily submitted data as well. Facilities submitting data manually were given the option of using a paper form, patient-specific, or aggregate Excel data collection tool.

Face-to-face meetings and teleconferences were held with LDO corporate representatives, other ESRD networks, the IHI team, the MRB and the Network 8 project workgroup to discuss project strategies and solicit input. Contacts were made to introduce the project to the three state Quality Improvement Organizations (QIOs), state survey agencies, state medical associations and state hospital associations. The Mississippi QIO, Information and Quality Healthcare (IQH), and the Mississippi State Hospital Association partnered with Network 8 in project promotion by publishing *Fistula First* articles in their newsletters.

Letters from the Network 8 MRB and project-marketing brochures were distributed to 500+ surgeons and interventionalists to introduce the Network 8 organization and *Fistula First* project. Introductory letters and brochures were also mailed to hospitals in the Network 8 region. Additional 2004 promotional activities included project exhibits at the National Kidney Foundation Spring Clinical Meeting in Chicago, the Mississippi State Medical Association Annual Meeting, and the Network 8 Annual Meeting.

The *Fistula First* project was first introduced to patients through articles in the Network's patient newsletter, *Kidney Patient Update*. The project was further promoted through two patient contests: "Why I Love My Fistula" essay contest and the "Longest Working Fistula" contest. Contest winners and winning essays were featured in subsequent patient newsletters.

**Educational Initiatives**

In 2004, Network 8 developed and provided educational resources and opportunities for clinicians and patients to promote *Fistula First* initiatives. Education was provided through regional workshops, the annual meeting, patient meetings, patient and professional newsletters, special mailings and the Network 8 website.

Regional workshops, provided for nephrologists, surgeons, and interventionalists, featured presentations made by workgroup physicians and local champions. Presentations described the roles of each practitioner and specific surgical and radiological techniques for vascular access. Workshops were held in Jackson, Mississippi; Birmingham, Alabama; Knoxville, Tennessee and Memphis, Tennessee. The Memphis workshop was held in conjunction with the Network 8 Annual Meeting and featured nationally known speakers, including Lawrence Spergel, MD, Clinical Chair of *Fistula First*.

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A vascular access assessment and cannulation workshop for nurses and patient care technicians was also held in association with the Network 8 Annual Meeting. Deborah Brouwer, RN, CNN, member of the national Fistula First leadership group and K/DOQI vascular access work group, was the featured speaker. The session was recorded for future video distribution to Network 8 dialysis facilities. Plans were made to repeat the program in 2005 regional workshops in Alabama, Mississippi and east Tennessee. An additional Fistula First session was held at the annual meeting, featuring a “vascular access” panel, describing the roles of vascular access team members.

Network 8 made Fistula First presentations for two Mississippi regional LDO meetings by request. Project initiatives and data were presented to regional nurse managers, quality managers and medical directors.

Patient meetings, held in each state, contained Fistula First presentations and vascular access educational materials were included in meeting packets. Educational articles were also included in the patient newsletter, and patient materials, such as the *Kidney Patient Update – Special Issue on Vascular Access*, were distributed in Fistula First facility toolkits, described below.

Utilizing tools compiled by the national tools and resources committee, Network 8 assembled and distributed a “Fistula First” facility toolkit to each dialysis facility. Toolkits were also made available to corporate quality contacts and will be distributed to new facilities as they are opened. The toolkit contains sample protocols, algorithms, forms, data collection tools, articles and resources.

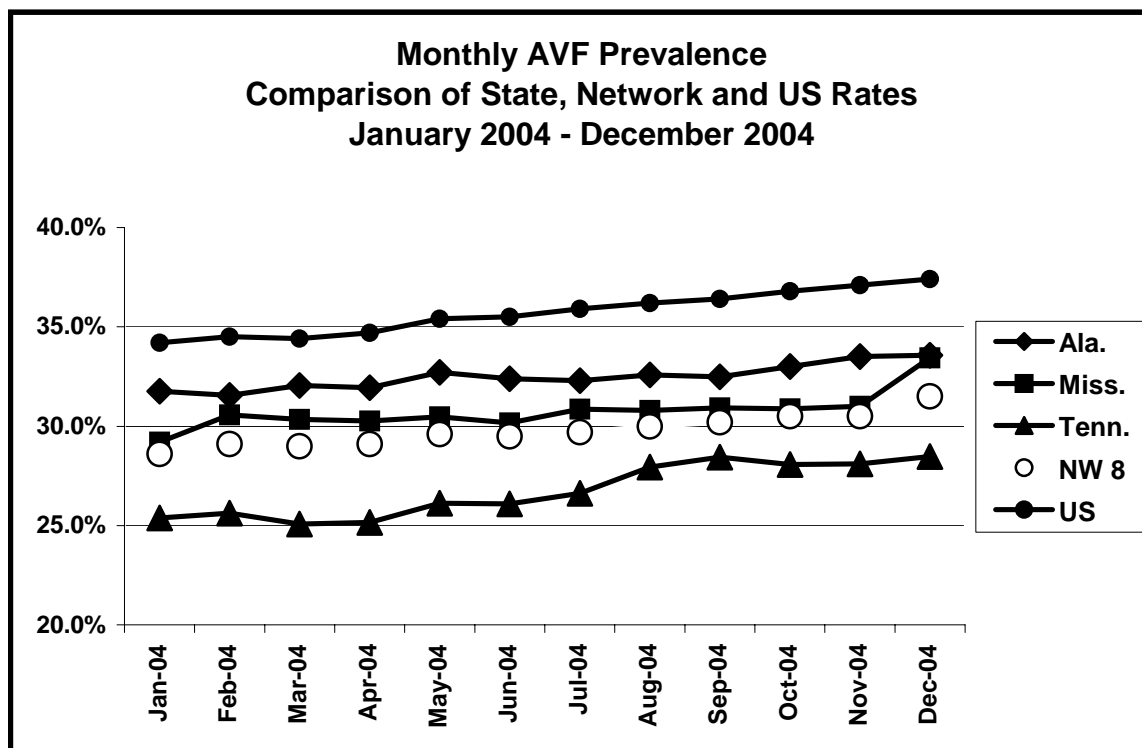
Network 8 initiated an ongoing “mentor service”, provided by volunteer surgeon members of the work group, which allows visiting surgeons to observe AVF procedures in the operating room. This service was advertised by mail to surgeons in the Network 8 area. Interested surgeons are provided a list of the mentors in each state. Scheduling of “mentor sessions” is left to the participating surgeon and mentor.

### **Data Outcomes and Process Analysis**

Progress in AVF rates was monitored monthly and quarterly on facility, state, Network, and national levels through facility-specific data and national data provided by the CMS Fistula First “dashboard”, a monthly running summary of AVF rates by ESRD Network. As of January 2004, with 95.1% facilities reporting (LDO + independent), the Network 8 AVF prevalence rate was 28.6% compared to the US rate of 34.6% (83.8% reporting). This represented a 2.3% increase for Network 8 over the baseline rate. By the end of 2004, with 98.2%

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of Network 8 facilities reporting, the Network AVF prevalence rate was 31.5%, a 5.2% increase above baseline, and 0.2% above target improvement goal assigned by CMS. Although the target rate of improvement was exceeded, Network 8 had the lowest AVF prevalence rate of all Networks, and remained well below the US average of 37.4% (92.8% reporting) and goal of 40%.



Network 8 QI staff reviewed data monthly for missing and questionable data and reported problems to the CMS data contractor and appropriate facility or LDO data contact. Problems detected included high percentages of patients reported in the “missing access type” category, high number of facilities with no catheters > 90 days, and discrepancies in prevalent patient counts when compared to Network records. As a result, data clean-up led to significant changes by year-end in access types within certain facilities and regions.

Fistula First data feedback report distribution began in January of 2004 and continued on a quarterly basis throughout the year. Reports included three standardized reports developed by the CMS data contractor, eSource, and two reports developed by Network 8. Standard reports describe the percentage of incident and prevalent patients in defined access categories (% AVF only, % AVG, % Catheter) and compare the percentage of patients using an AVF to the Network and US average. The reports developed by Network 8 describe the percentage of prevalent patients in each catheter category and the percentage using a catheter > 90 days compared to state and Network averages.

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Aggregate data were reported to facilities via the professional newsletter, *Network News*, and the Network 8 website. Facilities meeting the AVF prevalence goal of 40% were recognized in the professional newsletter and at the Network 8 Annual Meeting.

Three facilities from each state with the highest AVF prevalence rates were also recognized at the annual meeting.

Process analysis was conducted by telephone interviews with facility personnel. Nurses attending the Network 8 Annual Meeting were asked to describe practices used in relation to vascular access. Forty-seven facilities identified widely-used practices currently in effect and also processes that have not been adopted, such as routine referral of immature AVF to interventionalists, four weeks post-op. Results were reported in the *Network News – Winter Edition*.

Telephone interviews conducted with facilities with high improvement rates revealed practices leading to success, such as nephrologist involvement and increased communication with surgeons. Facility nurses, involved in successful access programs, presented their identified “best practices” and Fistula First activities at the Jackson, Mississippi cannulation workshop.

## **CMS Clinical Performance Measures (CPM) Project**

The following summary describes the CPM project, including details of how it was implemented for different target groups. Actual CPM results are described under "Network Quality Work Plan" on page 20.

Currently in its eleventh year, the Clinical Performance Measures (CPM) Project evolved from the 1994 Core Indicators Project (CIP) and established the first consistent clinical ESRD database. This project was implemented in response to the Balanced Budget Act of 1997, which required CMS to develop and implement by January 1, 2000, a method to measure and report the quality of renal dialysis services provided under the Medicare program. To implement this legislation, CMS funded the development of CPMs based on the National Kidney Foundation (NKF) Dialysis Outcomes Quality Initiative (DOQI) Clinical Practice Guidelines. On March 1, 1999, the ESRD CIP was merged with the ESRD CPM Project and this project is now known as the ESRD CPM project. The ESRD CPMs are similar to the core indicators with the addition of measures for assessing vascular access.

Each year the ESRD CPM project annual report is disseminated, providing fourth quarter CPM results on a sample of adult in-center hemodialysis patients and adult peritoneal dialysis patients. Findings on all pediatric patients (aged < 18 years) also are included. The report does not provide results on a dialysis facility-specific basis.

In 2004, the agreement that was reached between CMS and the Veterans Administration in 2002 to collect a 100% patient sample from VHA for both hemodialysis and peritoneal dialysis patients was still in effect. These forms were sent to Network 9/10 in hardcopy form for data entry and analysis. Although results will not be included in the annual CPM report, each VHA facility will continue to receive individual facility-specific profiles just as they have for the past 2 years.

In 2004, eSource became the contractor for all CPM data collection (other than the VHA), replacing Network 9/10 (Network 9/10 still retains the contract for the VHA data). eSource then began working with the LDOs to determine if they would be able to achieve an electronic submission of the LDO data, which would then be used to populate as much of their CPM forms as possible (particularly lab data). This data had to pass a series of checks to see if it was deemed satisfactory.

Non-LDO facilities were to be handled as they always had. The labels for the patients included in the 5% sample were received in the Network office in May and the forms were then sent on to the facilities for completion. The VHA forms

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were also sent for out for completion at this time. Networks were informed that hardcopy forms also would have to be sent for some LDO facilities for their peritoneal patients. This was also accomplished in May. According to the original CPM timeline it had been hoped that all LDO data could be sent electronically through Qnet in July. In June, a conference call was held by CMS that stated the sample was ready to download, but there were certain critical fields for every LDO that were not deemed satisfactory. These were then left blank and the Networks were instructed to send the forms to the LDOs with an instruction letter from CMS directing the facilities to fill in all blank items on the forms. Networks would then be permitted by CMS to call facilities and ask for corrections on the items that had been deemed critical. The forms were then sent to the LDOs in late June. Following a revision in the time-line, they were asked to have the forms back to the Network by July 23.

As forms were received in the Network office, data staff began entering the forms into the SIMS database. As the forms were being entered, certain questions regarding the accuracy of the forms began to arise. It was eventually determined that there were systemic problems that had happened during the electronic download from the LDOs. One corporation advised CMS that they had supplied weekly EPO doses for their PD patients instead of monthly and another LDO rounded all albumin values for HD and PD patients. Also, many facilities had been correcting data on the forms before returning them to the Networks, while many were not. The Networks and CMS then became very concerned about the validity of the data. A conference call was held where CMS told the Networks that they would be required to verify all the fields on both the HD and PD forms for accuracy and completeness. The forms were then reprinted and sent back to the facilities along with a verification statement. If the forms were correct, the facility simply had to fax the verification form back to the Network. If the forms were incorrect, the facility staff was asked to make the corrections, circle them, and send the forms back to the Network so that the correct data could be entered into the system. The forms were sent to the facilities in August and we did receive many phone calls and questions regarding this verification process. The timeline was revised with October 1 being the deadline for the completed data entry to be sent via Qnet. Our forms were entered and the process completed by the data staff before the deadline.

Data validation began in September. Requests for the patient charts for the 5% reliability sample were sent to facilities in September. The copied charts for all twenty-nine patients that were selected were all received back in the Network office by October 4. The charts were abstracted, the forms were completed and the data was entered into the database and sent to CMS by the November 1 deadline.

The 2004 preliminary findings were received in the Network office on November 30. This data will be used to for the 2005 CPM work plan.

## **Facility Specific Data Collection Using “Elab”**

Elab is the use of electronically-transmitted laboratory data on ESRD patients for quality improvement purposes. In 2001 Network 8 had joined several other Networks in a successful effort to reduce the paperwork burden on facilities and also to collect a population-based database rather than a sample. Participation in the 2003 phase of the Elab project continued in 2004

In 2004 CMS authorized eSource to begin acting as the primary contractor for the collection of lab data for Elab for facilities using national labs. Also, all 18 ESRD networks took part in Elab for the first time. Network 11 continued to serve as the contractor for facilities using non-national labs and to help in the reporting of data.

Most Network 8 facilities used a national lab and therefore were able to participate in the Elab project. Since data flows directly from national laboratories to project coordinators, facilities are relieved of the retrospective burden of record abstraction, and reports are more robust since they are drawn from the entire census, not a sample. Most facilities not affiliated with national labs chose to participate by manually entering data into a standardized spreadsheet. All of the facilities in the Network 8 area that do not use national labs had their spreadsheets completed and forwarded on to Network 11 by the end of January.

Networks received notice from Network 11 on January 20 that due to an unforeseen CLIA regulation, Medical Director consent authorization forms would need to be acquired from facilities affiliated with ESRD laboratories, Satellite Labs and Spectra West. A list of the facilities in the Network using these labs was e-mailed to the Network office. Because Network 8 had participated in Elab for the previous 2 years and had continued to obtain Medical Director authorization for new facilities, these signatures were already in the Network 8 office. The authorization forms were forwarded on to Network 11 in February.

The Elab reports were received in May and printed and collated. The reports were then mailed to facilities in July. Copies of the reports were sent to the medical directors, administrators and nurse managers. These reports were sent with letters from the Network 8 MRB acknowledging high performers and asking for improvement plans from low performers.

The Elab project, as originally developed, was not used to collect lab data for fourth quarter 2004. Several CLIA issues have caused the project to be shelved. Because this process has been beneficial to all, CMS agreed to allow Networks to receive certain Elab data elements through LDOs after they receive this information from their laboratories. This will allow facility specific data for to be used in Quality Work Plans. Networks will also be allowed to collect this

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information from our non-LDO facilities (on a volunteer basis) either manually or using a file spec that this compatible with other data. This is perceived as the first step for the upcoming Core Data Set. This information will include hemoglobin, pre/post BUN for URR for hemodialysis patients and hemoglobin and recorded Kt/V and CrCl for peritoneal patients. Data elements will be added to the Core Data Set as they become part of they become part of required CPM quality improvement activities (such as bone disease data, transplant elements, etc.).

## **Network 8 Quality Work Plan**

As required by CMS contract, each Network must develop a written plan, updated annually, to address specific Clinical Performance Measures (CPMs). The plan must include current and historical Network performance in relation to the CMS goals for each CPM indicator. The plan should outline and prioritize quality improvement activities and facility interventions designed to achieve desired outcomes and goals.

The 2004 Quality Work Plan was based on Network-specific data from the 2003 CPM Project report, received in 2004 (2002 4<sup>th</sup> quarter data); the facility-specific data, reported by ELAB in 2004 (2003 4<sup>th</sup> quarter data); and current Fistula First data. The work plan was submitted to CMS in January 2004. Following CMS-directed revisions, final approval was received May 6, 2004.

The MRB guided work in the following 2004 CPM goals:

1. Increase use of AV fistulas
2. Decrease catheter use
3. Improve anemia management
4. Increase stenosis monitoring
5. Improve hemodialysis adequacy.

The following text and data charts describe historical and current Network 8 performance in the CPMs, to be addressed in the current contract period, and work plan activities developed to address needed improvements. As some CPM goals have been met, Network 8 continues to strive beyond the goals and encourages facilities to do the same.

### **AV Fistula Use**

Network 8 demonstrated a slight (1%) increase in AVF use from 2002 to 2003, according to CPM data. Despite the increase, the percentage of prevalent patients using AVF in Network 8 remained well below the US average of 35% and CMS goal of 40%. Network 8, along with one other Network, had the lowest AVF prevalence rates in the nation. The CPM rate of AVF use in Network 8, derived from a random sample of patients, was comparable to the rate of 28.5% reported in December 2003 "Fistula First" data, with 93.7% of facilities reporting access data for 100% of patient population.

Increasing AVF prevalence was made the top priority for 2004 due to current and historical AVF prevalence in this region and potential long-term benefits to patients and providers. Quality improvement activities were designed to reach all parties involved in vascular access decisions and procedures. More details regarding

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interventions in this category are detailed in the Fistula First section of the annual report.

<b>Network 8 Performance – Vascular Access % of prevalent patients dialyzing with an AVF</b>						
	1999	2000	2001	2002	2003	2004
<b>CPM - NW (Oct-Dec)</b>	22%	22%	29%	27%	28%	NA
CPM – US (Oct-Dec)	27%	30%	31%	33%	35%	NA
<b>CDC – NW (Dec)</b>			24.3%	26.3%	CDC survey discontinued	
CDC – US (Dec)			30.4%	32.4%		
<b>FF – NW (Dec)</b>					28.5%	31.5%
FF – US (Dec)					34.2%	37.4%
<b>CMS Goal</b>	<b>≥ 40% of existing (prevalent) patients using an AVF and placement in at least 50% of new (incident) patients</b>					
Years above indicate the timeframe from which the data was collected. NA – data not available						

**Catheter Use**

Based on CPM data, chronic catheter use ( $\geq 90$  days) increased in the US in 2003, but decreased in Network 8. Network 8 continued to have one of the lowest catheter rates in the nation, 2% below the national average, but above the CMS goal of < 10%. The rate of chronic catheter use described in the CPM data was inconsistent with “Fistula First” data, which described a much lower use of approximately 12% for Network 8. This could be possibly attributed to the manner of data submission. (For more information see the Fistula First and the CPM data collection sections.) As Network 8 investigated a low incidence of chronic catheter use in a certain LDO, it was reported that catheter insertion dates were not always available, and therefore may be reported incorrectly.

The 2004 Network 8 work plan, designed to decrease the use of chronic catheters, included general educational activities and facility-specific interventions. The “Fistula First Change Package”, distributed by mail and presented in professional meetings, recommends certain practices to decrease catheter use. “Catheter-specific” tools were included in the Fistula First facility toolkit, which was distributed to all facilities. Patient educational materials provided information regarding the complications associated with catheter use. Revisions planned for the Network 8 website in 2005 will include addition of the Fistula First toolkit and other catheter information and resources.

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Data feedback reports, describing facility-specific catheter usage in comparison to state and Network, were distributed to all facilities. Using Fistula First data, Network 8 identified facilities with high rates (quarterly average  $\geq 28\%$ ) of chronic catheter use. This rate was selected due to the DOPPS data revealing a 23% increased relative risk of dying in facilities with  $\geq 28\%$  patients using catheters. This group of facilities received letters from the MRB describing the risks involved with catheter use and encouraging the use of tools to decrease catheter rates. Technical support by the MRB and QI staff was offered to assist in QI activities. The identified facilities will continue to be monitored for improvement, and intervention will be modified accordingly.

<b>Network 8 Performance – Vascular Access</b>						
<b>% of patients dialyzing with a catheter <math>\geq 90</math> days</b>						
	1999	2000	2001	2002	2003	2004
<b>CPM – NW (Oct-Dec)</b>	15-19%	12%	16%	19%	18%	NA
CPM – US (Oct-Dec)	14%	17%	19%	21%	20%	NA
<b>CDC – NW (Dec)</b>				18.5%	CDC survey discontinued	
CDC – US (Dec)				23%		
<b>FF – NW (Dec)</b>					12%	11%
<b>CMS Goal</b>	<b>&lt; 10% of HD patients</b>					
Years above indicate the timeframe from which the data was collected. NA – data not available						

**AV Graft Use and Stenosis Monitoring**

Network 8 had the second highest percentage of patients utilizing AVGs in 2003 (48%), compared to other Networks, and was well above the US average of 38%. Of all Network 8 AVG patients, 73% reportedly had an “acceptable” form of stenosis monitoring performed within the data collection period. As stenosis monitoring has increased each year in Network 8, with a significant increase following the 2001-2002 quality improvement project, the 2003 decline suggests a possible discrepancy related to the new manner of LDO data collection. With a CMS goal of 100%, much improvement is needed, regardless of the reason for data changes. In 2004, Network 8 provided stenosis monitoring tools and resources with the distribution of Fistula First toolkits. Additional educational activities are planned for 2005 including website revisions, newsletter articles, and meeting presentations.

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<b>Network 8 Performance – Stenosis Monitoring</b> <b>% of patients with AVG monitored for stenosis</b>						
	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
<b>CPM - NW</b>		<b>63%</b>	<b>68%</b>	<b>76%</b>	<b>73%</b>	<b>NA</b>
CPM - US	45%	47%	51%	61%	77%	NA
<b>CMS Goal</b>	<b>100% of patients with AVG</b>					
Years above indicate the timeframe from which the data was collected. NA – data not available						

**Anemia Management**

Network 8 made a significant improvement in anemia management in 2003, and exceeded the CMS goal of 70% for the fourth year. Network 8 also met the US average and ranked 9<sup>th</sup> when compared to other Networks.

<b>Network 8 Performance – Anemia Management</b> <b>% of HD patients with Hgb <math>\geq</math> 11.0</b>						
	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
<b>CPM - NW</b>	<b>69%</b>	<b>74%</b>	<b>73%</b>	<b>76%</b>	<b>80%</b>	<b>NA</b>
CPM - US	68%	74%	76%	79%	80%	NA
<b>ELAB – NW</b>	<b>NA</b>	<b>NA</b>	<b>74.6%</b>	<b>79%</b>	<b>78.1%</b>	<b>NA</b>
<b>CMS Goal</b>	<b>Attain/maintain 70 % of patients with Hgb <math>\geq</math> 11.0 gm/dl</b>					
Years above indicate the timeframe from which the data was collected. NA – data not available						

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**Hemodialysis Adequacy**

CPM data reported Network 8 with 89% of patients having a mean spKt/V  $\geq$  1.2. Although above the CMS goal of 84%, Network 8 showed a decrease of 1% since 2002 and ranked below the US average and 13 Networks.

<b>Network 8 Performance – Hemodialysis Adequacy</b> <b>% of patient with Kt/V <math>\geq</math> 1.2</b>						
	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
<b>CPM - NW</b>	<b>88%</b>	<b>89%</b>	<b>89%</b>	<b>90%</b>	<b>89%</b>	<b>NA</b>
<b>ELAB - NW</b>	<b>NA</b>	<b>NA</b>	<b>92%</b>	<b>93%</b>	<b>93%</b>	<b>NA</b>
CPM - US	84%	86%	89%	89%	91%	NA
<b>CMS Goal</b>	<b>84% of HD patients with Kt/V of 1.2 or 80% with URR <math>\geq</math> 65%</b>					
Years above indicate the timeframe from which the data was collected. NA – data not available						

2004 anemia and adequacy work plan activities included distribution of ELAB feedback reports, comparing facility performance to state and Network performances. Educational materials were provided to facilities through newsletter articles and mailings. Patient materials were included in regional PAC meetings materials. Facilities meeting and exceeding CMS goals were recognized in the facility newsletter and at the Network 8 Annual Meeting. Facilities failing to meet goal were targeted with direct intervention from the MRB, including letters offering technical support and direction for establishing a performance improvement plan. Specific tools were distributed to these facilities and further data submission was requested until goal reached. The identified facilities will continue to be monitored for improvement and intervention will be modified accordingly.

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**Nutrition**

The 2004 CPM data collection continued to include nutrition indicators, although the 2003-2006 CMS contract did not require them to be incorporated into the Network CPM work plan. Both Network 8 and the US showed a significant improvement in 2003 in the percentage of patients with adequate albumin levels. Network 8 continued to rank high among Networks, sharing the number 2 spot with one other Network. Calendar year 2004 data will be released in 2005.

<b>Adult In-Center Hemodialysis Patients with Alb &gt; 4.0/3.7g/dl (BCG/BCP)</b>			
<b>Year</b>	<b>US</b>	<b>NW</b>	<b>NW Rank</b>
1999	32%	33%	4
2000	29%	28%	7
2001	36%	36%	7
2002	35%	36%	5
2003	39%	43%	2

## **Educational Initiatives**

### **2004 Annual Network Council Meeting**

The 2004 Annual Network Council Meeting was held at the Hotel Hilton in Memphis, Tennessee, October 21-22. The meeting theme was "Putting it All Together: Increasing Knowledge and Skills to Improve Patient Care". Attendance total was 270 and included physicians, nurses, social workers, dietitians, renal administrators, patient-care technicians and 27 exhibitors.

Pre-meeting events on Thursday included a vascular access workshop, sponsored by Network 8, Inc., an Amgen dinner symposium, and a reception for meeting attendees. The vascular access workshop, entitled "Improving Vascular Access Outcomes: From Examination to Cannulation", featured Deborah Brouwer, RN, CNN. The Amgen dinner presentation focused on treatment of secondary hyperparathyroidism.

Cindy Powers, Network Council Chairman, opened the meeting on Friday morning. General sessions included presentations on "Fistula First", medications, and new trends in renal replacement therapy. Afternoon breakout sessions for nurses, dietitians and social workers were held. Clinical topics included patient coping strategies for thirst and infection control. Psychosocial sessions included information of the new Medicare drug benefit and vocational rehab. All disciplines reconvened for an afternoon general session, which provided an update on DPC, the project to decrease patient/provider conflict.

A separate physicians program, coinciding with Friday sessions, was held for the first time. The program was entitled "Placing Fistulas First...and Successfully: Current Strategies for Optimizing Patient Outcomes" and featured presentations by nationally known nephrologists, surgeons and vascular access interventionalists.

The meeting concluded with the completion of evaluation forms and the presentation of the re-elected Network Council officers. Overall meeting evaluations were positive and suggestions were received for future presentation topics and meeting locations.

### **Facility Newsletter**

Three editions of *Network News* were published and distributed to facilities and medical directors in 2004. Topics included Fistula First-related articles on project activities, goals, reports, and educational opportunities; CPM-related articles on anemia and adequacy; clinical articles on renal osteodystrophy, parathyroid hormone testing and palliative care; data department news items; discussion of the patient grievance process; influenza and pneumonia vaccination advice; and information on how to obtain technical assistance.

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**Patient Advisory Council (PAC) Meetings**

Network 8 held four PAC meetings in 2004. These were the traditional daylong educational seminars with one meeting being held in Mississippi, one in Tennessee and two in Alabama.

The Mississippi meeting was a joint meeting with the NKF of Mississippi. Ninety-six patients and family members attended the meeting, which was held at the Hilton Hotel in Jackson on August 15, 2004. The evaluations were consistently good to excellent for all presenters. Shad Ireland, the first dialysis patient to complete an Iron man Triathlon was the keynote speaker. Additional topics included dialysis and transplant medications, communicating with your physician, a grocery store shopping tour, Fistula First, and the Importance of Self-Care.

The Alabama meeting was again a joint meeting with the Alabama Kidney Foundation. Over 100 patients and family members attended the meeting that was held at the Birmingham Marriott Grandview Corporate Park on October 17, 2004. Reg Green, who donated his son Nicholas's organs for transplantation and Shad Ireland were the keynote speakers in two separate sessions. Other topics included Understanding the Transplant Waiting List, Transplant Medications, Fistula First, What transplant patients should know about Immunosuppression, a grocery store shopping tour, Will my kidney transplant last forever and the transplant process A – Z. The PSC presented on Patient's Rights and Responsibilities. The popular "Lunch With the Experts" was held again, but on a much more casual basis. One "expert" was seated at each table and conversation was dictated by the concerns of the table participants.

The Tennessee meeting was held on October 7, 2004 at the Embassy Suites Hotel, Nashville South in Nashville. The meeting was a joint meeting with the Middle Tennessee Chapter of the American Association of Kidney Patients. Shad Ireland, the Iron man triathlete was again the keynote speaker. Other presentations included Bone and Cardiovascular Disease in ESRD patients, New Issues in Dialysis and Transplant Medications, Preparing for a Transplant, How to Maintain your Lifeline (Fistula First), and Charting your Healthcare Course. Approximately 60 patients and family members attended the meeting.

A special meeting for Mobile, Alabama was scheduled to take place on September 9, 2004. This was to be a joint meeting with the Alabama Kidney Foundation and the University of Alabama Transplant Center. One hundred and fifty patients and family members had registered for the meeting when it had to be postponed due to Hurricane Ivan. The meeting was rescheduled for November 21 and the same speakers who were scheduled for Sept. 19 were able to arrange their schedules to come to the November 21 meeting. Flyers and brochures announcing the rescheduling were sent to everyone who had registered along with all of the dialysis facilities in South Alabama, South Mississippi and the Florida Panhandle (in partnership with Network 7). The

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meeting was held on November 21 with ninety-six patients and family members attending. Because the meeting could only be rescheduled for the Sunday before Thanksgiving, many of the people who had pre-registered were not able to attend because of the Thanksgiving holiday dialysis schedule. Reg Green and Shad Ireland once again were the keynote speakers. Additional topics included Maintaining your Lifeline: Ins and Outs of Vascular Access, Transplant medications, Transplant A – Z, Love the Skin Your In (Self-Esteem issues), What Hot and What's Not in Dialysis (new trends) and ESRD in the Minority Community. The PSC again presented on patient's rights and responsibilities.

**Transplant Poster Initiative**

Network 8 collaborated with the Network of New England (Network 1), enabling them to use the artwork from our transplant poster to print one of their own. The transplant posters continue to be disseminated to all new transplant facilities in our Network and also upon request.

**American Association of Kidney Patient (AAKP) Activities**

Two AAKP board members are from the Network 8 area. Brenda Dyson (Network 8's PSC) from Mississippi continues to serve as AAKP President and Ellie Durrett from Tennessee serves as an AAKP board member. Ms. Durrett is also President of the Middle Tennessee Chapter of AAKP.

The AAKP convention was scheduled to be held in Bal Harbour, Florida September 1 – 5, 2004. The PSC traveled to Bal Harbour to attend the convention and but had to return home the next day after Hurricane Frances forced AAKP to cancel the convention. This was the first time in 35 years that the AAKP convention has had to be cancelled. Each registrant did receive a convention package complete with all speakers handouts and materials, the convention t-shirt and other information. The next issue of aakpRenalife was a convention issue that had each speaker's presentation turned into an article for the magazine. The attendees were offered a refund for their registration fee or they could apply it to the 2005 convention in Las Vegas. Ellie Durrett received the AAKP Spirit of Service Award for 2004 because of her efforts in educating the public about CKD.

Two "Finding Your Strength" programs for CKD patients were held during 2004. Ellie Durrett hosted an event in Nashville on August 15 where approximately 35 CKD patients were taught about kidney disease and its complications. The PSC hosted an event in Jackson (MS) on October 9, which had around 20 patients and family members in attendance.

The PSC attended the RPA meeting in Washington, March 20 – 21 representing AAKP and also hosted the AAKP Medal of Excellence, on Sunday, March 21. Dr. Morrell Avram was honored with the award for 2004. This award is presented

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annually by AAKP to a physician who has dedicated his or her life to improving the lives of kidney patients. Also, prior to the RPA meeting, AAKP hosted a meeting of the Renal Coalition on March 21. The PSC also presided over this meeting.

The PSC represented AAKP and Network 8 at the NRAA/RSN meeting that was held in Denver, September 30 – October 3. This was the inaugural meeting for the Renal Support Network which is a national patient organization concentrating on policy and advocacy issues. The PSC attended session at both the NRAA and RSN meeting and participated in-group discussion on how to increase advocacy among kidney patients. The PSC also attended the ASN meeting in St. Louis in October as a representative of AAKP.

The PSC continued to represent AAKP and Network 8 as a member of the Task Force for the Decreasing Dialysis Patient/Provider Conflict (DPC) group that is attempting to design an action plan for addressing conflict management in the dialysis facility. Two meetings were held during 2004, both in Baltimore. On February 24, the group was shown a timeline for implementation of the project. The purpose of this meeting was to build a consensus on the use of definitions and taxonomy. A subcommittee was formed to complete this task. Another subcommittee was formed on Legal/Ethical/Regulatory Issues and one was formed to develop a DPC toolbox that will be sent to every dialysis facility. The group also met on May 25. We were shown how work had progressed on the contents of the toolbox and on the WebEx training session which will be available both on CD and on the Forum website for facility training. The taxonomy and definitions were almost finalized and the legal/ethical/regulatory committee had made considerable progress in working toward a DPC Position Paper on Involuntary Discharge. The goals of the project are to provide safe dialysis facilities and improved staff/patient relationships through a national collaboration. Mark Meier who is the chair of the Toolbox Committee presented on this initiative at the Network 8 annual meeting, which was held in October. Another task force meeting is scheduled for January 2005 to assess the timeline for rolling out the project.

**National Kidney Foundation (NKF)**

The Patient Services Coordinator continues to collaborate with the National Kidney Foundation on several initiatives. The PSC attended the U.S. Transplant Games that were held in Minneapolis, Minnesota on July 27 – August 1. She attended the games as a participant on Team Mississippi. These games continue to set records as the largest gathering of transplant recipients and their family members in the country. The games are not only about athletic competition, but are used as a vehicle to show the public that transplantation works and to encourage organ donation. The Games hold both living donor and deceased donor recognition ceremonies to express gratitude for the gift of organ donation. A member of Team Mississippi met the mother of his heart donor at

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the 2004 games. They were featured on national television spots and spoke during the opening ceremonies. Prior to the games, the PSC participated in numerous fundraisers and organizational activities to prepare for the trip.

Both the PSC and QIC continue to serve on the NKF of Mississippi's Professional Advisory Board. Efforts of the Board this year have included the Kidney Calendar (the PSC is featured as the Patient of the Month for November) and the first annual KIDney Kids Retreat. This retreat was held at the Henry S. Jacobs Camp in Utica, Mississippi. It was held on May 22 – 23. Ten children ages 8 – 16 and several parents attended the camp. Activities included a rope course, a talent show and dance, crafts and games, along with psychological and medical counseling. The PSC served as a counselor for the camp

The PSC and ED also continue to serve on the Board of Trustees of the NKF of Mississippi. Network 8 staff continues to be available as needed workshops and events throughout the Network. The PSC also is available to speak as needed to the local chapter of the Patient and Family Council of NKF and spoke to this group in February of 2004.

Network 8 staff continues to be involved with the NKF of Mississippi in conducting their Kidney Early Evaluation Program (KEEP). The purpose of the screenings is to identify individuals at risk for kidney disease and encourage them to seek further evaluation and follow-up from a physician. The tests given at the screenings include blood pressure, blood glucose using a glucose monitor, microalbuminuria, pyuria, hematuria, serum creatinine, hemoglobin and calculated creatinine clearance. The patients are given an opportunity to confer with a physician on-site and some have recommended immediate follow-up even before all of the lab results are returned. The tests are sent to a lab for analysis and the results are sent directly to the patients with follow-up recommendations. The findings have been very eye opening. Of the people screened over 50% have shown to have some form of kidney disease. Several screening were held in 2004 including screenings on March 20, March 25, April 22, June 26, and August 21. The PSC continues to be involved in the screening as volunteer coordinator.

**National Kidney Disease Education Program (NKDEP)**

Jackson, Mississippi, was chosen as one of four pilot sites for the National Kidney Disease Education Program (NKDEP), who's goal was to target and educate high risk groups for prevention of kidney disease. Other pilot sites were Atlanta, Cleveland, and Baltimore. The PSC, QIC, and ED served on the Steering Committee and the PSC was named a co-chair for the pilot along with Dr. John Bower and Lynda Richards of the NKF of Mississippi. The project got underway in 2003 and continued through May of 2004. The PSC, along with several other people from the Jackson coalition attended a meeting of the pilot site participants that was held in Washington, D.C. on February 27.

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The PSC attended a Diabetes Symposium on January 24 where NKDEP exhibited. Brochures were given out and the video was shown. Additionally NKDEP brochures were added to an information packet that was given to all members of the state legislature during Capital Day in Jackson. This event was sponsored by the Mississippi Chronic Illness Coalition (MCIC) and was held on March 3. A dinner planning meeting was held for the entire Jackson coalition on January 15 and was attended by the PSC and ED. It was decided at the meeting that the Jackson coalition would work with TV and Radio stations to try to get coverage. Both of these outlets were very receptive. Two coalition member nephrologists were featured on a local noon talk show in March and all local radio stations aired the PSAs. The print media also continued to provide excellent coverage. A front-page article was featured in Mississippi's largest newspaper on March 15 and this article was picked up and featured in the e-mail newsletter of the Mississippi Hospital Association. A billboard was unveiled on March 1 near the Jackson Medical Mall and ran for well over a month. Materials were also given out at all of the KEEP screenings.

Network 8 provided NKDEP with addresses and contacts for the local dialysis facilities and several new educational tools were sent to the dialysis facilities in late January. These were also to be displayed at the facilities and given out to patients. Additionally, Network 8 prepared a poster for the CMS/Forum annual meeting and displayed it during the poster session. It cited Network 8's participation in NKDEP and the goals of the project. Educational videos and brochures were given out to all Network PSC during the PSC breakout session.

On May 3 a meeting was held to wrap up the pilot at the NKF of Mississippi office. The official conclusion for the Mississippi Pilot was May 4. A post-test was done to determine if the project had raised awareness about kidney disease in the minority population, but results have not been published yet. The program has gone nationwide currently. Network 8 has included the information in the patient packets that were given out in all three states at the PAC meetings and will continue to promote this educational effort.

**Educational Media for Patients**

The Network's patient newsletter, *Kidney Patient Update*, was distributed twice in 2004. The Spring edition of the patient newsletter was sent to providers in April 2004. It included the winners of the "Why I Love My Fistula" contest along with their winning essays. Updates on the Network 8 grievance policy, DFC, rehab resources and the continuing features, "The Doctor Is In" and "The 20 Year Club" were also featured. A new contest featuring the longest lasting fistulas in our Network was announced. The Fall edition of the newsletter was sent to facilities in September. It included updates on the winners of the "Why I Love My Fistula" contest along with a reminder about the longest lasting fistula contest. Information about the flu and hurricane season was also included along with the necessary precautions patient need to take in preparation for these events. The

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bulk of the newsletter was dedicated to articles on bone disease, but did include the continuing features, "The Doctor Is In" and "The 20 Year Club".

Network 8-developed disaster manuals continue to be included in the new facility packets. These manuals contain local emergency contact information for each area of the Network. The manuals also contain a section in the back of the book for patient preparedness. Facilities are asked to copy this section and make sure that all patients have it on hand in case of emergency.

The most requested Network produced item continues to be the patient education book, *Understanding Kidney Failure and Selecting a Treatment Modality*. This has been reprinted numerous times and continues to be available free of charge to all facilities, hospitals, and doctor's offices in the Network upon request. The book is currently being updated to reflect new trends and modalities.

Additionally, the transplant poster that was developed and distributed in 2003 continues to be included in the new facility packets.

**Other Meetings and Activities**

The PSC and QIC continued to serve as members of the Mississippi Chronic Illness Coalition (MCIC) that is working to address the needs of the chronically ill within the state of Mississippi.

The PSC also continues to serve as a member of the Consumer Advocacy Council (formerly the Beneficiary Liaison Committee) with the Mississippi QIO. This council meets quarterly during the year.

The PSC attended and presented to the Alabama Adult Kidney Camp in Jackson Gap, Alabama on April 24. She presented on services provided by Network 8 and also on empowerment issues.

The PSC worked with the other Network PSCs during 2004 to develop an internal toolkit that will help Network Patient Services Personnel address incoming complaints from facilities and patients. This was reviewed during the PSC breakout at the Forum meeting in Baltimore in March and at the PSC retreat that was held on December 3 in Orlando in conjunction with the Network 5 End of Life Conference. The toolbox is awaiting approval from the EDs before using it internally at each Network. The PSC group also worked on patient educational materials for Fistula First at this conference and these will be distributed to each Network for use in 2005.

The PSC and QID each attended the End of Life Conference in Orlando in December.

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The PSC presented a session on Kidney Disease and the ESRD Networks to the Health Information Management Class at the University of Mississippi Medical Center on September 27.

The PSC continues to serve as the Region 3 representative to the Patient Affairs Committee of the United Network of Organ Sharing (UNOS). The PAC held two meetings in 2004. The PSC attended the April 19 – 20 meeting and the September 20 – 21 meeting. Both were held in Chicago. She also attended the Region 3 meeting, which was held in Richmond, VA on March 26. Additionally, the PSC attended a retreat, which was held on September 23 at the Airport Hilton in Chicago. It was held to determine if changes needed to be made to the current kidney allocation policies and, if so, to develop proposals for policy modification accordingly. This meeting was held on behalf of the OPTN/UNOS Kidney and Pancreas Transplantation Committee and the PSC represented AAKP during this meeting. The committee then formed a task group to undertake a much more thorough review of the situation and make recommendations.

The PSC and ED participated as members of a CMS workgroup whose goal is to develop a CAHPS survey to determine the patient's experience of care in the dialysis unit. The survey was presented in draft form at the CMS Stakeholders meeting that was held following the Forum meeting in Baltimore in March. Both the PSC and the ED attended this meeting. Much discussion ensued and many changes were suggested to be made to the draft document. Several conference calls were held in 2004, both with the workgroup and with the Network EDs to discuss ways of piloting the project. Other issues involved in the discussion included the length of the survey, the structure of the questions and the choices, the wording of the questions and how this document could be used in QI activities. Piloting began in 2004, and 30 thirty facilities across the US were selected. The sample met specific geographic, racial, and other criteria. Over-sampling was used because many patients will choose not to participate. The Network provided the patient lists from the selected facilities to CMS, who supplied them to RAND, lead grantee on the pilot. The survey type was either telephone only or mixed mode (phone and mailed paper survey). Patients in both modes were given explicit guidance about getting assistance from family or friends. Following the pilot testing of the survey, three Networks have volunteered to work with 2 facilities in their Networks to test how these surveys can be used for quality improvement projects.

### **Examples of Educational Materials Supplied to Patients or Facilities**

- Patient compliance video in new facility packets
- CMS patient disaster manuals as needed and at PAC meetings
- Phase I of AAKP's Patient Plan on request
- AAKP convention brochure mailed to facilities
- Medicare supplement handbook at PAC meetings
- CMS adequacy brochure at PAC meeting
- Network 8 special editions newsletters on DOQI Guidelines, transplantation, nutrition and vascular access at PAC meetings
- Network 8 latest edition patient newsletter at PAC meetings
- AAKP adequacy brochures for HD and PD at PAC meetings
- AAKP Patient Plan brochure at patient meetings
- NKF Family Focus newsletter, Transplant Chronicles newsletter and informational brochures at PAC meetings.
- Network 8 modality book at PAC meetings and to facilities as requested
- AAKP, NKF Patient and Family Council and transAction membership brochures at PAC meetings
- AAKP Na-K-Phos Counter and Protein and Calorie Counter at PAC meetings
- AAKP's The Iron Story at PAC meetings
- AAKP's Vascular Access brochure at PAC meetings
- AAKP latest edition Renalife and Kidney Beginnings at PAC meetings
- ESRD Federal Regulations to facilities that request them
- Mary Rau-Foster book on dealing with difficult patients in new facility packet and on request
- Network 6's Vascular Access Brochure in new facility packet
- Life Options' rehabilitation self-assessment tool for facilities
- Network 8 transplant poster
- Network 8 Fistula First brochure
- Patient and facility newsletters
- QI improvement manual using anemia model
- RPA guidelines for initiation/discontinuation of dialysis
- Dialysis Facility Reports supplied by the CMS contractor
- NKDEP materials
- AAKP Kidney Beginnings for CKD patients
- AAKP Hemodialysis Access brochure at patient meetings

### **Other Technical Assistance to Providers/Facilities**

Ongoing assistance is provided, either through direct consultation or referral, for clinical matters such as anemia management, interventions to improve hemodialysis adequacy, bone disease management, infection control, and AVF

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cannulation techniques. Requests for educational articles of varying content are also fulfilled. Additionally, assistance is provided in relation to CMS forms and with interpretation of questions on CMS, USRDS, and CDC surveys. Many questions were received about the DFRs that were sent out in September.

The Network received many questions regarding the new Medicare Law and the Prescription Drug Coverage Benefits. We had several concerned calls and e-mails from area transplant pharmacies that have been hit hard by the 10% decrease for Medicare immunosuppressant drug coverage. We continue to answer insurance questions and termination of benefits questions or refer them as appropriate. We have also continued to refer patients and facilities to the Dialysis Facility Compare website and also to the Home Dialysis Central website.

Broadcast faxes were sent out regarding flu vaccine availability, new prescription drug benefits and disaster preparedness.

As mentioned, Network 8 did send out a fax-blast reminding facilities to be prepared for what might occur during Hurricane Ivan. This was sent out on September 9. Following this, 2 facilities did call and request help in preparing their back-up plans for their patients. Additionally we did receive six requests for preparedness manuals for facilities and patients and these were sent to providers. Copies of the new CMS facility manual along with the patient manual also continue to be included in the new facility packets. Network 8 also continues to include copies of the Network 8 specific disaster preparedness manual in our new facility packets and as requested from dialysis facilities and corporate offices. The Network also worked closely with the Dallas RO, the State Survey Agencies (SSA), the State Emergency Operations Centers (FEMA) and the LDOs and other dialysis facilities during Hurricane Ivan and it's aftermath in trying to place displaced patients and making sure that our facilities were getting the help they needed. Emergency contact information for SSA, Network and RO was provided to facilities along with toll-free numbers of LDOs for patients making dialysis arrangements. Lists were also provided to FEMA agencies with the request that dialysis facility be given priority status for utility repair.

## **Other Activities Related to Improving the Quality of Care**

### **ESRD Outpatient Medications Project**

The Network entered into a special contract with CMS on July 1, 2004 for the ESRD Outpatient Medications Project, whose aim is to establish a baseline for medication use by ESRD (CKD stage 5) dually-enrolled patients and to identify instances of inappropriate medication use that warrant further review.

Establishing baseline medication use by ESRD patients will assist in the implementation of the Medicare Modernization Act (MMA) Part D prescription program through better understanding of existing ESRD prescribing regimens.

The University of Mississippi School of Pharmacy serves as the key subcontractor charged with receiving and merging CMS data files and creating profiles. The Mississippi QIO, Information and Quality Healthcare, was initially consulted for guidance and assistance with formation of a technical expert panel. The technical expert panel is guiding the classification of ESRD medications and working to clarify appropriate and inappropriate usage in this special population.

Other areas of investigation may include estimating the scope of inappropriate medication use such as drug-drug and drug-disease interactions, duplicative therapy, excessive drug utilization, underutilization of medications, and use of medications that should be avoided in the ESRD population. Project baseline data will offer the potential for determining the patient impact of medication errors and for identifying opportunities for prevention. The one-year project concludes June 30, 2005.

### **Bone Disease Management Project**

Using ELAB data, Network 8 developed facility profiles based on bone disease indicators. The profiles reported the percentage of patients meeting K/DOQI targets for both phosphorus and PTH and compared facility performance to Network performance, which was 31%. The data analysis also revealed a number of facilities with a low percentage of patients having both tests performed during the data collection period (October – December 2003).

Reports were distributed to facility medical directors, dietitians and nurse managers. Educational materials, including K/DOQI pocket guidelines, were included in the dietitian mailing. Articles were published in the facility newsletters, one focusing on Network 8 performance in bone disease management, compared to K/DOQI guidelines (Spring 2004 edition), and the second focusing on parathyroid hormone testing (Winter 2004 –2005 edition). Additional articles were published in the patient newsletter (Spring 2004 edition).

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In conjunction with the 2004 Network 8 Annual Meeting, Amgen sponsored a pre-conference dinner meeting, featuring a presentation on a new treatment for secondary hyperparathyroidism. Preliminary plans for the 2005 Annual Meeting agenda include additional presentations focused on bone disease management.

**Transplant Advisory Committee (TAC)**

During June 2004 analysis began on transplant status information provided by facilities in 2003 using a then-approved collection form. The initial analysis included state-level aggregate counts of the reported transplant status of Network 8 patients as of December 31, 2003. This information was acquired using a Network 8 specific data collection instrument that has now been eliminated by CMS. More analysis was done including breaking out categories by age, race and gender and also looking at facility specific information including which facilities have a low referral rate or who referred no patients in 2003.

In August, the TAC chairman reviewed an analysis of the data and requested inclusion of additional profiles. That analysis was completed in September and forwarded to the Chairman. In November, the TAC chairman agreed that the data analysis done by Network 8 was ready to be shared with the other members of the TAC. The analysis was forwarded to the TAC in November along with several options for a time to have a conference call. The call took place on December 8 with 4 committee members in attendance and one absent. The goals of the TAC were reviewed and agreed upon and the data tables were discussed for relevance. The ED acknowledged that the data sources used to prepare these table were no longer available for years after 2003 due to constraints on what Networks may collect.

Two TAC recommendations from 2004 were subsequently accepted by the MRB in 2005. Graphs and accompanying tables will be constructed for each facility, depicting the percentage of patients in the various categories: waiting; in evaluation; refuses; medically unfit; and not established. Also, blinded, aggregate data tables will be constructed and mailed to LDOs so that they will see their comparative performance.

**Glomerular Filtration Rate (GFR) Profiles**

Annually, Network 8 produces provider profiles that identify facilities in which more than 10% of new patients were started on dialysis with a MDRD-derived GFR greater than two standard deviations above the mean. During the reporting period of July 1, 2003 through June 30, 2004, 12 facilities were identified. Medical directors of these facilities received letters from the MRB asking that they comment on the clinical circumstances of initiation of dialysis if originally-submitted labs were correct.

### **United States Renal Data System (USRDS) Special Studies**

Five studies were planned for the USRDS Special Studies contract. The first of these to be implemented, the Cardiovascular Study, is being done to collect data on the clinical characteristics of dialysis patients suffering acute myocardial infarction in the United States.

Several roadblocks continue to hamper this study. At the end of 2002, forms for the deceased patients had been sent to dialysis units for completion (it had previously been determined that we could collect the data on the deceased patients because they were not considered "human subjects" for the purpose of human subjects research). Because of ongoing IRB issues live patients (who were considered "human subjects") could not be included in this initial phase of the study. Subsequently, because of staffing concerns, several LDOs imposed a moratorium on their staff to block their completing the forms for deceased patients. Because of this issue only about 60% of Network 8's forms that were sent out for deceased patients were returned. The forms that we had received were sent to USRDS on March 7, 2003, after being checked for completeness.

In June 2003, we submitted to CMS an estimated cost analysis on travel to dialysis facilities to complete the Cardiovascular Special Study Forms. Then in September 2003, a conference call was held to given the Networks an opportunity to clarify certain issues with CMS and USRDS. Consent forms had to be changed to comply with IRB and the new forms were received in the Network office in October.

Following the receipt of the new consent forms, work began again on the study. CMS and USRDS had now decided to make living patients the priority for the remainder of the study. Consent forms for patients who were still living as of September, 2003, were sent to facilities in October with instructions on how to proceed with handing the forms out to the patients and returning them to the Network. A few patients did refuse to sign, a few more had passed away, and one was deemed incompetent to sign. Altogether we received 19 signed consent forms of patients who were willing to take part in the study.

USRDS and CMS then decided to group the data collection for the living patients with forms for any expired patients who were dialyzing at that facility at the time of their death and whose charts were retrievable. Additionally any expired patients whose facilities were within a 60-mile radius of Jackson were also added to the study. This would total approximately 70 charts with the Network 8 area if all the charts were retrievable.

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Network 8 submitted a modified budget to CMS in January 2004 to abstract the charts. We received word in mid-January that our estimated budget had been accepted. Travel to the facilities for chart abstraction began in March and was completed in May.

Our estimate that we could complete 70 charts was made assuming all the charts that we requested would be retrievable and that we would be allowed access to them. Due to non-uniform LDO participation and lack of access to several charts, the Network completed only 56 of these charts (16 living patients and 40 expired). They were all mailed to the USRDS on May 21, 2004 before the deadline for the project.

Following the completion of the Cardiovascular study, the Network did see our outline of what the Comprehensive Study will entail. We did not receive any timeline regarding this study in 2004.

### **Centers for Disease Control (CDC) Data Collection**

During 2003 Network 8 was engaged by CMS to receive from each ESRD Network their collected CDC surveillance forms, to key the data, and to produce output reports of the results. Delays in the process began with a later than usual distribution of the approved form by CDC to Networks, leading to extensions in the date forms were due to each Network office.

Additional delays were encountered as the project progressed including staffing changes at Network 8. Additional work was undertaken to verify the accuracy of queries underlying output reports, and by the end of 2003, quality checks were ongoing to promote data accuracy and completeness. Errors discovered on facility forms from a number of Networks were reported to those organizations in an effort to improve reporting results. In January 2004, following final data entry of corrections submitted by several Networks, binders containing hard copy reports were distributed to each Network, along with a CD containing Network-specific data.

Calendar year 2002 was the last collection by Networks of data represented on CDC forms. CMS and CDC collaboratively decided in 2004 not to continue the annual data collection.

### **CPM Data Collection for CMS**

See page 17 under CMS clinical performance measure section.

## Evaluating and Resolving Patient Grievances

### Background

The Network has consistently endeavored to maintain an effective initiative for evaluating and resolving patient complaints/ grievances. Network providers are required to post a copy of the Network grievance policy where patients and families have easy access to it (e.g., bulletin boards) in waiting areas. New facilities receive a copy of the Network 8-Grievance Policy in the new facility information packet and the grievance procedure is posted on the Network 8 website. Newly diagnosed patients are informed of their right to contact the Network or state agency to voice their concerns. A new Grievance Poster is under development with distribution scheduled for early 2005

The Network continued in 2004 to distribute to all facilities the resource manual, "Dealing with Challenging Patient Situations: A Practical Handbook of Expert Guidance" by Mary Rau-Foster. This manual addresses many topics and situations that are experienced in the dialysis setting. It offers guidelines for handling conflict, and assistance in developing policies and procedures.

During 2004, the PSC participated in the CMS sponsored DPC project as a member of the task force. Also Mark Meier of Network 11 presented at the Network 8 annual meeting on the DPC.

### Scope of patient concerns

The chart below provides a historical overview of the contacts that were received in the Network office over a 4-year span (2001- 2004). The contacts were classified according to the definitions and coding by CMS.

SIMS CONTACT SUMMARY				
Historical Overview: 2001-2004				
Category	CY 2001	CY 2002	CY 2003	CY 2004
Grievances/ Complaints	22	15	28	30
Beneficiary Inquiry	9	5	50	16
Facility Concerns	54	63	63	52
Facility Inquiry	30	103	104	307

**Grievances** are requests for a formal investigation of a serious complaint involving a facility, physician, or other provider (quality of care issue). **Complaints** are requests for assistance on behalf of an ESRD patient regarding concerns about ESRD issues including, but not limited to, care or treatment. This could include mediation activities. **Beneficiary Inquiry** is a request for information, advice, referral, or educational material

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that does not require problem resolution. **Facility concerns** are requests (from staff) for guidance or advice/assistance in handling difficult issues that are patient related (clinical or behavioral). **Facility inquiry** is request (from staff) for information, advice, referral, or educational material that doesn't require problem resolution.

In 2004, the Network 8 staff received and processed 405 patient related contacts ranging from beneficiary complaints to simple requests for basic educational materials. The Network did not receive a formal grievance during 2004.

Once again, many concerns were from facility staff seeking guidance and assistance with difficult patient situations. Because Network staff has been able to assist in these situations, the number of formal grievances and complaints has not increased significantly during the year 2004. The Network staff strives to resolve complaints and intervene with facilities to keep complaints from going to the Medical Review Board. However, in some cases the Medical Review Board is consulted. The PSC did participate in two on-site mediations during 2004.

Contacts received at the Network were classified according to CMS definition. Below is a summary of the contacts that were received during calendar year 2004.

**Formal Grievances:** As stated, there were no "formal grievances" during 2004.

**Beneficiary Complaints:** 30 Opened - 29 Closed

In most cases, Beneficiary Complaints focused on issues in which the Network mediated between patient and staff. Many concerns were due to a lack of communication or miscommunication between patients and staff. Several contacts involved issues addressing staffing shortages and training of new staff and in several instances complaints involved staff refusing to care for patients who could not address their own bodily functions. In response, Network staff contacted the Administrator, Director of Nursing or Social Worker of the facility to facilitate patient interaction. Some concerns involved environmental issues such as thermostat control in the unit, lack of proper infection technique, communication, patients wanting to change shifts so they could work more easily and care for their children and cleanliness. When necessary, Network staff contacted the Nurse Manager, and/or the Administrator and requested specific documentation to assist with investigation of the concern. When indicated, the calls were referred to the state agency for investigation. In order to promote communication, the Network continued to encourage the use of patient meetings and patient newsletters within the facility and dissemination of policy changes or general information to patients.

**Beneficiary Inquiries:** 16 Opened - 16 Closed

These patient contacts were for information about services such as insurance coverage, transportation, or access to care. When appropriate, the names and telephone numbers of agencies or individuals who could assist with the resolution were provided. Also included were calls in which there was an issue

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with finding transient dialysis, and concern about facility requirement for transient dialysis or cancellation of transient dialysis after initial acceptance. Several of these calls were referred to DFC. Some other questions came from CKD patients and were listed under "Other Inquiry".

**Facility Concerns: 52 Opened - 52 Closed**

Contacts regarding disruptive/challenging patients continued to account for the greatest number of calls from facility staff. These complex situations compromise the safety of staff and fellow patients. Patient actions have ranged from verbal threats to actual physical attacks against staff. Network 8's approach included advising the facility to contact the local police for assistance if there appeared to be immediate danger. Many times a behavioral contract was developed with the patient for this purpose. On a number of occasions, after hearing the concern, Network staff suggested that the facility refer the patient for psychiatric intervention. All facilities were advised that transfer of the patient must occur within the established CMS regulations. When the behavior represented an immediate and serious threat, the facility arranged for the patient's dismissal. In some instances, this meant that the patient was referred to local emergency rooms for care, but in all cases, we stressed that the facility must then make all efforts to find the patient a place to dialyze. Network 8 also assisted in contacting facilities and exploring other treatment options for these dismissed patients. In several cases, we were able to get the patient placed in another facility associated with the same corporation and the patient was able to keep their own physician fairly often.

**Facility Inquires: 307 Opened - 307 Closed**

Facility inquiries involved consultation with the Network for guidance in facility decisions such as termination of patient-physician or patient-facility relationships. Other inquiries included: difficulty with payers addressing a payment issue, transportation services, and request for educational materials and technical assistance on clinical issues.

During this year Network 8 also received 83 "Other Inquires". Several of these came from acute hospitals where dialysis facilities were refusing patients and the hospital was not able to discharge the patient to a nursing home. Additionally some acute hospitals did call because they were having to dialyze patients that had been discharged from all potential dialysis facilities in the area and were just showing up in the emergency room. Network 8 assisted these facilities as possible.

## **II. Improving Data Reporting, Reliability, and Validity Between ESRD Facilities/Providers, Networks, and CMS**

### **Hardware and software infrastructure**

All computer hardware utilized by Network 8, Inc., as well as CMS-leased equipment, met or exceeded minimum CMS requirements designed to establish uniform architecture among the Networks. The Network utilizes Windows 2000 on the workstations and a Dell server for centralized storing and replication.

User workstations have access to a shared hard drive and shared software. All user workstations are connected to the server for access to patient, facility, and Network data. This server, router, switch, and CSU/DSU interface provide WAN connectivity to CMS and to other Networks. Computer security includes battery-back-up devices to reduce power interruptions for both the file servers and the desktop units. An internal tape back up unit on the server performs nightly automated full-system back ups. Back-up tapes are rotated off-site on a weekly basis, and interim tapes are stored in a fireproof cabinet.

### **Custom Data Capabilities**

In order to produce a wide array of tables, graphs, and charts for profile analysis by the MRB and for processing data requests, Network 8 uses an internal software module (Net8Ware), created locally.

### **Data Security**

The Network office is equipped with a monitored burglar, smoke, and fire alarm system. Security of forms and other hard copy data is maintained in locking fireproof filing cabinets and standard locking office filing cabinets.

Local database information is backed-up regularly by an automated tape back-up device. This system operates after hours, preventing daily system down time. Back-up tapes are stored off-site in a bank vault on a weekly basis.

### **Data Requests and CMS Forms Processing**

Network 8's Data Systems staff processed 10,031 CMS Forms during the 2004 calendar year. Forms processed included 5,711 CMS 2728 forms and 4,338 CMS 2746 forms.

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The number of CMS 2728 forms may not match the number of incident cases in 2004 because the number referenced above includes forms received in 2004 for 2003, excludes 2004 forms received in 2005, and accounts for 2004 forms received, entered, and submitted to CMS for patients later determined to be acute.

<b>CMS Forms</b>		
	<b>HCFA 2728</b>	<b>HCFA 2746</b>
2004	5711	4320
2003	5305	3838

The Central Repository provided all data transmissions and forms submittals to CMS. This process ensures that all replications accurately communicate the data from the local Network to the Central Repository.

**Accretions, Data Element Changes, and Notifications**

As part of the CROWN network of databases REMIS receives data from sources other than the Networks. REMIS compares this information to that received from SIMS. If there is a discrepancy REMIS notifies the Network via SIMS Accretions and Notifications. This provides the Network with the opportunity to agree and correct SIMS records or disagree and reject the REMIS data.

The Network processed 9,570 Accretions and Notifications (Data Element Changes) received via SIMS and processed 48 requests for data in accordance with Federal guidelines for release of data. A file is maintained in the Network of all data requests.

	<b>Accretions and Notifications</b>	<b>Medicare +CHOICE Requests</b>	<b>Data Requests</b>
2004	9,570	275	48
2003	12,937	457	13

**Monitoring Facility Compliance with CMS Forms**

Forms compliance is calculated using CMS timeliness and accuracy guidelines. To help facilities correct compliance problems, we send a list of submitted forms to each clinic semi-annually. This list includes a description of the error(s) and on time versus late. A list of forms that are missing (detected by a mismatch in data from the Network’s Monthly Census Report) is sent to the clinics every quarter.

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In an effort to help clinics improve their compliance ratio (timeliness and accuracy), clinics that had not met the CMS goal of 90% were sent a list of Most Common Errors and a form on which to complete a Corrective Action Plan. Many clinics did a good job of evaluating their forms-process and making adjustments as needed to avoid errors or late submissions. In 2004 58.2% of the clinics improved over their 2003 Compliance Rate, and the number of clinics meeting the 90% goal increased 11.9%.

Special emphasis is given at year-end to obtain CMS forms that have not been submitted.

**CPM Data Validation**

See discussion on page 18 under CMS clinical performance measures.

### **III. Establishing and Improving Partnerships and Cooperative Activities Among and Between the ESRD Network, QIOs, State Survey Agencies, and ESRD Facilities/Providers**

#### **Quality Improvement Organizations (QIOs)**

Network 8 provided Fistula First information to each of the three QIOs, in the Network 8 region. The Mississippi QIO featured a Fistula First article in their publication, and the Tennessee QIO plans to do so in 2005. Communication regarding the upcoming QIO 8<sup>th</sup> Scope of Work (SOW) that will include "Fistula First" initiatives began in December 2004, and plans were made for increased collaboration in 2005, following receipt of the SOW.

For information on the ESRD outpatient medication project with Information and Quality Healthcare (IQH) – Mississippi QIO see summary under "Other Activities Related to Improving Quality of Care".

The Network is a member of the IQH Consumer Advocacy Council, which meets quarterly to discuss the needs of the state's Medicare beneficiaries in Mississippi.

#### **State Survey Agencies**

In 2004, Network 8 continued to collaborate with the three survey agencies (SA) in improving the quality of care for ESRD beneficiaries. Informal communication was utilized for problem solving, sharing of information and requests for assistance. As the Network received copies of facility surveys, technical assistance was offered and educational materials were provided to facility staff. Common deficiencies will be addressed in future Network educational activities.

The Network worked closely with the Tennessee SA and CMS RO on two cases in 2004.

- Phone calls were received by a physician and patient that described failure of facilities to administer Epogen as prescribed. Once complaint was referred to State Survey Agency, a site visit was made and complaints were verified. Financial reasons were cited as the reason for failure to administer medications. The state agency received an acceptable corrective action plan and the Network continued to monitor the facilities and provide technical support throughout the year.

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- The CMS RO made a referral to the Network regarding a facility with multiple patients dialyzing twice weekly. The medical director was sent a letter from the MRB that emphasized K/DOQI adequacy goals and the need for the physician to include residual function in the calculation of Kt/V whenever anything less than thrice weekly dialysis was contemplated. Specific guidance was offered on educating resistant patients of the health dangers of under dialysis. The Network requested submission of lab data to describe the level of residual renal function of affected patients. The Network will continue to provide technical assistance and follow-up as needed.
- During the hurricane season, Network 8 worked closely with the SAs and FEMA to monitor the status of facilities and patients. These efforts were coordinated through the Dallas RO. Emergency contact information for SSA, Network and RO was provided to facilities, along with toll-free numbers of LDOs for patients making dialysis arrangements. Lists were also provided to FEMA agencies with the request that dialysis facilities be given priority status for utility repair.

## **Partnerships with ESRD Facilities**

See summary above regarding the hurricane season.

## **Partnerships with Other Networks**

**Patient Education.** The artwork for the Network 8 transplant poster was shared with Network 1 during 2004. We also partnered with Network 7 who went out information to their Florida Panhandle patients about the Patient Meeting that was held in Mobile. Network 8 requested and received copies of Grievance Posters used by the other Networks as we work to make a poster available to our facilities in early 2005.

**ELAB.** See discussion on page 19.

**Fistula First.** See discussion beginning on page 12.

## **Additional Areas of Improved Partnerships**

**MCIC.** The PSC and QIC continued to serve as members of the Mississippi Chronic Illness Coalition (MCIC) that is working to address the needs of the chronically ill within the state of Mississippi.

**ANNA.** The Network QID and QIC continue to maintain ongoing communication with both the national American Nephrology Nurses Association (ANNA) organization as well as local chapters within our network.

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**AAKP.** During the past year, the PSC continued to be actively involved with the American Association of Kidney Patients (AAKP), serving as the President of the Board of Directors.

**NKF of Mississippi.** The PSC and ED serve on the Board of Trustees of the NKF of Mississippi. The PSC and QIC serve as members of the Professional Advisory Board and are both actively involved in the Keep screenings and many other activities.

**LORAC.** The ED serves as the ESRD Network representative on the Life Options Rehabilitation Advisory Council (LORAC). The function of the council is to advise the Life Options staff on strategies for education and research to promote improved quality of life for ESRD patients.

**NKDEP.** (National Kidney Disease Education Program) – Network 8 has partnered with the NKF of Mississippi and other area organizations to serve on the advisory committee of this initiative. The ED, QIC and PSC serve on the advisory board and the PSC is a co-chair of the initiative. The initiative is sponsored through NIDDK. See additional information under “Patient Centered Activities and Resources”.

**UNOS.** The PSC currently serves as the Region 3 representative to the Patient Affairs Committee of the United Network of Organ Sharing (UNOS).

## **IV. Support the Marketing, Deployment, and Maintenance of CMS Approved Software.**

The Consolidated Renal Operations in a Web-enabled Network (CROWN) network, an integrated ESRD information system, facilitates the collection and maintenance of information about the Medicare ESRD program, its beneficiaries and the services provided to them. The three components are designed to work together to enable electronic exchange and validation of data that is transformed into usable information.

The three components of the CROWN system include:

- SIMS (Standard Information Management System)
- REMIS (Renal Management Information System)
- VISION (Vital Information System to Improve Outcomes in Nephrology)

### **SIMS**

Each ESRD Network has a local SIMS database that provides communication and data exchange links among the Networks, the facilities, and CMS. Networks enter patients' registration information, which is updated and stored for replicated routine replication to a central repository

SIMS produces:

- national and local prevalent patient rosters that list the patients and the events for a given year.
- 2744 forms to aid facilities in completing their annual survey forms and for helping to reconcile the Network database. The validated data is patient-specific and provides elements such as age, race, sex, ethnicity, diagnosis and modality/setting of care, as well as patients' county and state of residence and date of onset of ESRD.
- a summary of key events in ESRD patient history, including all changes in modality, setting, and provider.
- data compliance reports called for in the scope of work.

## **REMIS**

REMIS (Renal Management Information System) receives data from multiple sources. CMS and ESRD Networks are able to use this feature to:

- resolve discrepancies in demographic data without having to call on dialysis or transplant facility staff to verify the information.
- determine event histories from billing data, in order to round out patient event histories.
- discover data provided from sources such as Social Security that allows the resolution of chronological histories.

## **VISION**

Earlier versions of VISION were revised and released in Q3 of 2004. With that release CMS established the VISION goal for each Network: 40% of the 28 VISION-eligible clinics will be trained and 20% will be transmitting via VISION by spring of 2005.

With this goal in mind, Network 8 sent VISION Readiness and Interest forms to each of its 45 Independent facilities. By the end of December, 38 facilities had been declared eligible, 20 facilities expressed interest (10 having been trained on the previous software, but not yet participating). A training course was scheduled for January for seven clinics that wanted training immediately and retraining was scheduled for the 10 clinics previously trained. A Training Budget was submitted to CMS and approved.

## **Sanction Recommendations**

Network 8, Inc. did not initiate sanctions against any facilities during 2004 for failure to cooperate with Network or CMS goals.

## **Recommendations For Additional Facilities**

The boards of Network 8, Inc. made no recommendations for additional facilities in the region. The competitive climate among dialysis corporations has resulted in continued expansion into areas that can economically support new facilities.

## **Data Tables**

The tables on the following pages were created per CMS specifications, and depict information as of December 31, 2004. Patient registration and event updates are provided by the facilities to the Network. The Tables represent information based on a reconciliation of 2004 events performed by the facilities and the Network in March 2005.