

Network 8, Inc.

2003 ANNUAL REPORT

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Preface

We witnessed a major shift in the scope of our quality improvement activities in 2003 when CMS endorsed the National Vascular Access Improvement Initiative. Although facilities continue to have a front-and-center role in assuring the success of the project, the focus of activities now has extended beyond the provider level.

The Fistula First project has allowed us to open doors with a broader community, including the specialties of surgery and radiology. It has caused us to begin thinking about how to move upstream to the primary care community of physicians and nurse practitioners, and to patients themselves.

We have been encouraged by an enthusiastic outpouring of support from nephrologists, surgeons, and radiologists in all three states. The challenge will be to develop communication linkages among these groups and to make the successes of early adopters clearly visible to those who are still on the sidelines. Promotion of best facility practices in maintaining patency of fistulas will need to become a part of the way we all do business.

This Network was the pilot site of an important and related project, the National Kidney Disease Education Program. This NIH initiative afforded four U.S. sites, including Jackson, Mississippi, the opportunity to interact with CKD patients and their providers in an effort to hone a concise message of empowerment to patients who are at greatest risk for kidney disease. It is our hope that knowledge gained from this project will be useful in promoting co-management of CKD patients by PCPs at the appropriate clinical stage.

These and other activities of the Network organization are included in this report. We would like to acknowledge the effective work you are doing on a daily basis to deliver quality care to renal patients in this region. Keep up the good work.

Sincerely,

Phillip W. Rogers, MD, Chairman
Board of Directors

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Introduction

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.

The Network program was implemented four years later 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.

Networks are under contract with the Centers for Medicare & Medicaid Services (CMS) to perform a variety of services. 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.

Activities performed by Network 8 and its partners to advance these goals are summarized in this report.

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I. **Network Description.** This geographic region includes Alabama, Mississippi and Tennessee, covering 50,750, 46,914, and 41,220 square miles respectively (138,884 square miles total). Although all three states are typically rural, the expansion of dialysis units into new communities over the past few years has improved access to ESRD care. There exists substantial cultural and economic diversity from state to state and within states. Population data 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
Race						
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
Hispanic/Latino						
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
Race						
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
Hispanic/Latino						
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

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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), directs QI activities and projects, serves as liaison to the Medical Review Board, directs the activities of the QI nurse, and assists in the development and implementation of Network educational workshops.
- Rosemary McElroy, RN, CNN, Quality Improvement Coordinator(QIC), serves as the primary contact for the patient grievance process and as liaison to the MRB patient grievance committee. Additionally, she provides day to day technical assistance to providers and assists in other assigned QI activities.
- Brenda Dyson, Patient Services Coordinator (PSC), assists with the patient grievance process, produces the quarterly patient newsletter, coordinates patient education, serves as liaison with allied state and national renal patient organizations, and coordinates the distribution of CMS, USRDS, and CDC data collection instruments.
- Michael Kennedy, Information Systems Director (ISD), managed the data department, supervising four data specialists through the end of November, at which time he accepted a position with eSource. He was 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, responds to patient status requests from CMS, and installs routine CMS/eSource software updates.
- Katie Wilcher, Data Specialist, enters and validates data from CMS and Network forms for the state of Alabama, serves as backup to the Office Manager for logging incoming mail, and processes returned new patient packets.
- Lynn Haynes, RN, Special Projects Coordinator, assists with educational meetings such as the Network's 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 on policies and administrative matters), and appoints the Medical Review Board.

Board of Directors as of December 31, 2003	
Philip W. Rogers, MD, Chairman Hattiesburg, MS	Sergio Acchiardo, MD, Vice-Chairman Memphis, TN
Kent Taylor, MD Secretary/Treasurer Selma, AL	Cathy Folk, RD Nashville, TN
Wilson Parry, MD Jackson, MS	Tom Ozbirn, DO Birmingham, AL
Alp Ikizler, MD Nashville, TN	Ellen Predmore, MSW Chattanooga, TN
Cynthia Powers, Network Council Chairman Memphis, TN	Charlotte Baynes, Patient Representative Pinson, AL
Renay Sykes, RN Grenada, MS	Martin Lee, MD Tupelo, MS
Carol Headley, MSN, RN, CNN Memphis, TN	Marc Stegman, MD Memphis, TN
Angie Kurosaka, Administrator Birmingham, AL	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. The MRB oversees the Network’s quality initiatives with guidance from the CMS central and regional offices with technical direction from CMS government task leaders. The MRB generally mirrors the Board of Directors in composition and representation. Among its principal objectives are to develop and implement quality improvement initiatives and to evaluate facility and patient concerns. Patient and facility grievances and concerns are also considered by the MRB. On-site investigations occasionally are undertaken by the MRB or by staff under MRB direction.

Medical Review Board as of December 31, 2002	
Jerry Jackson, MD, Chairman Birmingham, AL	Marcelo Ruvinsky, MD, Vice-Chairman Jackson, MS
Suzanne Bergman, MD 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, RN Columbus, MS
A. Randle White, MD Greenwood, MS	Santiago Vera, MD Memphis, TN
Paul McGinnis, MD, Patient Representative and Grievance Committee Chairman Jackson, MS	

Network Council

The Network Council is an advisory body to the Board of Directors. Membership consists of one health professional representative appointed by the facility with no term limits. Additionally, the patient advisory council chairman from each state serves on the Council.

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 were reelected in 2003 to an additional two-year term of office.

Network Council Officers		
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 to represent its patients on the state's 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.

Patient Advisory Council Officers		
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. The MRB transplant surgeon serves as chairman of the committee.

TAC members provided leadership and technical direction for the creation of an informational poster that assures each patient the right to be evaluated for transplant and which lists each transplant facility in the Network, along with contact information.

The poster was distributed to each dialysis and transplant facility by direct mail and has been distributed in additional venues, including the Network display booth at the 2003 annual meeting in Birmingham.

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Transplant Advisory Committee Members		
Chairman	Santiago Vera, MD	Tennessee
Member	Shirley Schlessenger, MD	Mississippi
Member	Martha Tankersley, RN, MSN	Alabama
Member	Luke Wright, MD	Tennessee

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

Quality Improvement Projects and Activities

Fistula First: The National Vascular Access Improvement Initiative

With the CMS initiation of ESRD Performance Based Service Contracts beginning in July 2003, Fistula First: the National Vascular Access Improvement Initiative was developed. CMS partnered with the Institute of Healthcare Improvement (IHI) and the 18 ESRD Networks to establish a quality improvement project to improve vascular access outcomes, primarily by increasing the use of the AV fistula as the primary hemodialysis access.

The project was developed due to the increasing problems associated with the hemodialysis vascular access, including increased hospitalization rates, costs, morbidity and mortality. It has long been determined that the most preferred type of access is the native AV fistula (AVF), which is known to have longer patency rates and is associated with fewer complications, such as thrombosis and infection. The goal of increasing the use of AVF would thereby decrease complications leading to decreased morbidity, mortality and costs.

CMS established goals for the Vascular Access Clinical Performance Measures (CPMs) to reflect the K/DOQI practice guidelines for vascular access. These goals, which include the use of a primary AVF in 50% of all new patients beginning hemodialysis (incident patients) and 40% of all prevalent patients undergoing hemodialysis, are also the goals of the Fistula First initiative.

Compared to European countries and Japan, which report AVF prevalence rates as high as 90%, the US has significantly lower rates of AVF use. (DOPPS) The CPM data collected in 2002, reported a prevalence AVF rate of 33% in the US. CDC data collected in 2002, reported an AVF prevalence rate of 32%. Both CPM and CDC data show a varied rate of AVF use across Network regions, with a range of 25% - 48% in prevalent patients (2002 CDC). The Network 8 prevalence rates reported from CPM and CDC data collected in 2002 were 27% and 26%, respectively. CMS plans to assign each Network a target goal for improvement, ranging from 3%-5%, based on their current AVF prevalence rates (2002 CDC data).

A national work group, comprised of CMS, IHI, Network and renal community representatives, was established to develop the project initiatives. This led to the release of the Fistula First Change Package, a set of recommendations based on best practices for increasing AV fistula use, which became the foundation of the project.

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The project was introduced to the Networks during the CMS/IHI/Network conference in June 2003. Each Network went forth from the conference to work with their individual Medical Review Boards (MRB) in establishing project strategies for their region. Project development continued throughout 2003 though face-to-face meetings and teleconferences with CMS, IHI, other Networks and representatives from the renal and medical communities.

Network 8 introduced the Fistula First project with an awareness campaign beginning in August 2003. Project announcement letters were mailed to facility medical directors, administrators, nurse managers, social workers and dietitians. Facility specific vascular access data reports and the Fistula First Change Package were included. Announcements were also sent to quality managers and medical leaders of dialysis corporate chains. A poster exhibit at the 2003 Annual Network 8 Meeting in Birmingham, Alabama, promoted the project, and meeting materials included a project information sheet. A Fistula First page was added to the Network 8 website.

A database of vascular access surgeons and radiologists was developed by surveying dialysis facilities in the Network 8 region. This will be used to deliver the Fistula First project information, tools, and activity announcements to key vascular access team members.

Network 8 established a vascular access project workgroup through nominations from the Board of Directors and Medical Review Board members. Nominations included nephrologists, surgeons and radiologists who were committed to increasing the use of AV fistulas in our region. The group first convened in October 2003 in Kenner, Louisiana prior to the Network 13 Vascular Access Conference. The project was introduced during a dinner meeting, and strategies were discussed. Workgroup members attended the Network 13 conference the following day. Following the meeting, workgroup members were surveyed regarding their desired level of project participation. Members agreed to activities such as making presentations, writing newsletter articles and providing technical support to requesting physicians. The workgroup was also surveyed to determine strategies having the greatest impact on vascular access outcomes. Members ranked surgeon education as having the greatest impact on outcomes, and education for nephrologists and nurses as second. A workgroup teleconference will be scheduled in January 2004 to discuss further strategies.

Educational workshops are being planned to begin in the spring of 2004. Four regional workshops for nephrologists, surgeons and radiologists will feature presentations on the project initiatives and technical approaches to successful vascular access programs and fistula placement. Regional cannulation workshops for nursing personnel will begin in the summer or fall of 2004. The

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2004 Annual Network meeting will feature a physician track for vascular access presentations by nationally known speakers and a pre-meeting vascular access workshop for nurses and patient care technicians.

Facility and patient newsletters featuring Fistula First articles were released in December 2003. The newsletters will be utilized to provide educational articles and announce project activities. A patient essay contest, "Why I Love My Fistula" was announced in these editions. Contest winners will receive a prize and recognition. Winning essays will be published in future newsletters to encourage patients to choose AVFs.

A Fistula First marketing brochure was developed by Network 8 and will be distributed in 2004 to surgeons, radiologists and other healthcare providers and organizations. The brochure will also be distributed while exhibiting at professional meetings. The brochure contains the announcement from CMS, the change package, vascular access data, names of national and regional workgroup members and project references.

Monthly vascular access data was received electronically through SIMS from Large Dialysis Organizations (LDOs), in order to reduce the burden on facilities. Monthly data will be collected manually or electronically via EXCEL spreadsheets from independent facilities beginning in January 2004. Data will be reviewed for progress and feedback reports will be distributed quarterly to facilities.

Planned strategies for 2004 include extended outreach to dialysis providers at facility and management levels, patients, surgeons, radiologists, primary care physicians, QIOs, state surveyors, medical associations and professional societies. Project toolkits will be developed and distributed to facilities. Technical assistance from workgroup members will be provided by request through face-to-face meetings or teleconferences.

2003 CMS Clinical Performance Measures

The clinical performance measures (CPM) project, currently in its tenth year, grew out of the 1994 Core Indicators Project (CIP) and established the first consistent clinical ESRD database. This project grew out of 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.

The ESRD CPM project annual report is disseminated each spring and provides 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.

Although there are no CPMs established specifically for the pediatric age group, demographic and clinical information is collected on all pediatric patients in the U.S. in order to describe several indicators of dialysis care. These indicators include hemodialysis adequacy, vascular access, anemia management and serum albumin. These are analyzed and pediatric specific special reports are then prepared and disseminated.

In 2003, 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 did in 2003 for 2002 data.

For all other facilities, CPM data were collected in the spring of 2002, entered into the VISION software by each Network, and sent electronically to the CMS contractor (NW 9/10) in July of 2003 analysis. We subsequently received two other databases (along with all the other Networks) which listed several problems (related to VISION) that needed to be corrected. Network staff worked together running correction programs, calling facilities and re-entering data until these issues were corrected. Following the completion of data entry, the requests for facilities to copy records for CPM data validation were sent out. We then received the copied charts for all thirty-two patients that were selected

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for the data validation. This was abstracted by the QI staff and entered in VISION by the data department and sent electronically to NW 9/10 by October 2, 2003. Because of the all the problems encountered in the use of the VISION software, release of the preliminary data for this project was delayed until December 1, 2003. We then had 60 days from the date that the data was received to submit our Quality Work Plans to our Project Officer. This will be sent by January 30, 2004. Once again data were collected on 15 CPMs including KT/V, albumin, hemoglobin and vascular access.

Results for CY2002 in the 2003 CPM Annual Report. Network 8 facilities continued to rank high in adequacy and for the first time in 2 years, we did show an increase in the percent of adult hemodialysis patients who have a KT/V \geq 1.2. We had held steady at 89% for two years, but this year we reached the 90% threshold. The U.S. average was again 89% and Network 8 ranked sixth in the nation in this measure of adequacy. 87% of patients had a URR of \geq 65%, which exceeded the US average of 86 and the CMS goal of 80% and ranked in a tie for fifth place among the Networks.

Trends for adequacy are shown below:

Adult patients with Kt/V > 1.2			
Year	US	NW	NW Rank (of 18)
1999	84%	88%	3
2000	86%	89%	3
2001	89%	89%	7
2002	89%	90%	6

Anemia management showed an increase in performance, but still ranked below the national average. Network 8 had 76% of adult hemodialysis patients with a Hgb. value \geq 11. The average in 2002 was 79%. Despite the fact that the region met the CMS goal of 70%, Network 8 was tied for 16th in rank, again indicating considerable room for improvement.

Nutritional measures stayed the same. Among adult hemodialysis patients, 36% have a mean serum albumin of 4.0 or greater. The Network average was also 36% in 2002. The current U.S. average is 35% and Network 8 tied for 5th among other networks, meeting the CMS goal of 35%.

The table below shows trends for anemia and albumin:

Year	Patients with Hgb > 11			Patients with Alb > 4.0/3.7		
	US	NW	NW Rank	US	NW	NW Rank
1999	68%	69%	7	32%	33%	4
2000	74%	74%	7	29%	28%	7
2001	76%	73%	17	36%	36%	7
2002	79%	76%	16	35%	36%	5

Vascular Access

Data sources on fistula prevalence which were contradictory in 2002 between the 2001 CMS random sample (n<500), which indicated a sharp increase to 29% from a flat rate of 22% in 1999 and 2000, and the population-based CDC data for the same period showing a prevalence rate of 24%, were much more balanced in 2003. The CPM data showed a “decrease” from 29% to the more believable 27%. The national average for the CPM fistula data is 30% with a goal of 40%. The CDC data showed an increase from 24.3% to 26.4%. Network 8 ranked 16th among the 18 networks in fistula prevalence for the 2002 CPM data.

Catheter prevalence also increased in the CPM measures. Network 8’s prevalence of patients with catheters for ≥ 90 days increased from 12% in 2000 which ranked first in the nation to 16% in 2001 and then to 19% in 2002. According to the CPM rate, Network 8 providers have consistently managed to maintain a prevalence well below the US average, but are showing a steady increase. This will be addressed in the 2004 Quality Work Plan.

Stenosis Monitoring was chosen by Network 8 as the topic for the Quality Improvement Project which ended with the last scope of work. We worked aggressively on this topic during 2001 and 2002. This intensive work has really resulted in improvement. Network 8 has a large percentage of AV Grafts and we believed it to be in the best interest of our patients to make sure that these grafts were being properly cared for. The national average for percent monitoring has always been below the Network 8 average, but the CMS goal is 100% and we are still far short of that goal. In 2000, our baseline for the QIP showed Network 8 to have an average of 63% with the US average at 47%. The year 2001 showed Network 8 at 68% and the US at 51% and for 2002 which marked the conclusion of our QIP, Network 8 had risen to 76% with the US at 61%. This topic will continue to be addressed through the 2004 quality work plan.

Fistula and catheter trends (using CPM data only) are shown below:

Year	Patients with AVF (See text for discussion)			< 10% of Prevalent Patients with catheters \geq 90 days		
	US	NW	NW Rank	US	NW	NW Rank
1999	27%	22%	15	NA	NA	NA
2000	30%	22%	17	12%	17%	1
2001	31%	29%	10	16%	19%	5
2002	33%	27%	16	19%	21%	5

Network 8 Facility Specific Data Collection Using “Elab”

Network 8 continued its participation in the Elab project in 2003. In 2001 we joined with several other Networks in an effort to reduce the paperwork burden on our facilities and also to collect a population-based database rather than a sample. Elab is the electronic exchange of laboratory data on ESRD patients for quality improvement purposes.

There are several advantages of Elab which, as mentioned, includes reduction of paperwork for both dialysis facility staff and Network personnel thereby reducing the possibility of errors. The electronic transfer of data permits compilation and analysis of large data sets, not just small samples and the facility-specific reports can be generated quickly with comparative data by facility, state and network and over time we can generate trends for each facility.

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 of our facilities not affiliated with national labs did choose to participate by manually entering data into a standardized spreadsheet. In at least one facility group, a data extraction method was devised locally so that only a small portion of data had to be entered manually.

Medical director consent and laboratory affiliation from had been obtained from existing facilities in late 2001 and consent and lab affiliation for facilities that had

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opened in 2002 were obtained in late 2002. Once again, in September of 2003, we began contacting new facilities to obtain both medical director consent and laboratory affiliation. These were obtained and forwarded on to NW 11 in late 2003. The facilities using non-national labs were contacted in November 2003 and were sent the spreadsheets for them to complete manually. The facilities were to complete these spreadsheets and return them to Network 8 by the end of January 2004.

In January 2003, Bio-Consulting Lab (BCL), a department of the University of Minnesota began receiving the 2002 data from the national labs. The data collected is for the same time period as the CPM data, October through December 2002. The majority of facilities using non-national labs did submit their data in 2002 which was forwarded to Network 11 to be checked for errors and then sent on to BCL. This was all completed by March 2003.

We received the CD containing Network 8 facility specific results along with State and Network data in the office in mid-May. Internal analysis of this data led to a discovery that problems had existed with the original database and we did ask Network 11 to rerun our sample. This was done and the more accurate results were received in late June. The reports were run and sent to all Network 8 facilities on July 8, 2003.

Once again, in analyzing the data received for 2002, some discrepancies between the ELAB data and the CPM data were noted. In anemia, the CPM data showed Network 8 with 76% of the population with Hgb. ≥ 11 , ELAB showed 79%. For adequacy, CPM showed Network 8 with 90% of the population with a KT/V ≥ 1.2 , ELAB showed 92.8%. The discrepancies may be attributable to differing sample sizes of the two collection methods.

The MRB continues to look at this data in determining where to target our efforts regarding non-CPM improvement projects. We began in late 2003 to look at bone disease as a possible project using the osteodystrophy data from Elab as a baseline for the project.

With one entity producing reports, Network organizations similarly are relieved of redundant data entry and report generation. Networks receive pre-formatted reports electronically and create a master report for each facility. Copies are made for each medical director, administrator, and nurse manager. Response to the project has been positive, both for the improved quality and range of standard reports and for the appreciated reduction in facility work burden.

Network 8 Quality Work Plan

The Network 8 quality work plan that was developed in 2002 and approved by CMS in October 2002 was still in effect during the calendar year 2003. Network 8, along with all other Networks, did not receive our preliminary 2002 CPM data until December 2003. We then had 60 days to develop our 2004 Quality Work Plan and it was due back to the regional office by January 30, 2004. The Work Plan that was in effect during 2003, used combined CPM and Elab results. Our region achieved national targets for adequacy, anemia and albumin, but these were all included in the work plan in an effort to promote continuous quality improvement. CMS had Networks to develop work plans in 2002 because of the move toward performance-based contracts in July 2003. CMS will continue to set national goals for all the Networks to meet on the Clinical Performance Measures (CPM). While CMS has indicated that each Network region may not be able to meet these goals immediately, Network organizations have been asked to develop quality work plans outlining activities and interventions to address the national goals. The Network 8 work plan that was in effect in 2003 included the following indicators, goals and targets.

AV Graft Stenosis Monitoring

Goal: 100%, Network 8 Performance: 68% (up to 76% in 2002 CPM data), US: 51% Failure rate: 32%, Target Performance: 90.4%

Because the 2002 Quality Improvement Project for Network 8 was stenosis monitoring, this CPM was assigned top priority during 2002 and early 2003. This region has a large percentage of patients with synthetic grafts, which reinforced the need for routine access monitoring. Two elements of QIP were completed in 2003. The Final Project Report was sent on to CMS in March 2003, which was by the CMS deadline, and the report back to the facilities was done via the annual report, which was sent to facilities in 2003. The final report showed that facilities did adopt some form of surveillance, though many of them chose something other than the two MRB-recommended methods (Flow Monitoring and Static Venous Pressure Monitoring). The number of patients with positive indicators increased, as did the number who were referred for intervention. The thrombosis rate decreased to the K/DOQI level during the observation period. The MRB concluded that surveillance would likely be done more effectively if reimbursement were allowed for flow monitoring since it provides greater assurance that a procedure is actually indicated.

Additionally data validation on a sample of records in early 2003 indicated that the information reported throughout the QIP was accurate with no deviations found.

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Interventions that continued into 2003 included patient education through distribution of vascular access material and inclusion in materials developed for facilities for the Fistula First project.

AV Fistula Prevalence

Goal: 40% of prevalent patients; Network 8 performance: 29% (down to 27% in 2002), US 31%, Failure rate: 11%, Target performance: 31.2%.

CPM results indicate that although improvement has been made, Network 8 remains below the US average for prevalent fistulas. Increasing fistulas is a priority for this region because of the known long-term benefits to patients and because of the emphasis put on fistulas by the National QIP (Fistula First) that got underway in July 2004. More details regarding interventions in this category are detailed in the Fistula First section of the annual report.

Catheter Prevalence

Goal: <10% of prevalent patients with catheter > 90 days, Network 8 performance: 16% (up to 19% in 2002), US: 19%, Target performance: 15.7%

The Network currently has one of the lowest catheter rates among the 18 regions, but there is room for improvement on this indicator. Network 8 chose to make this a QI activity using the 2002 work plan. The project was started in late 2003 to reduce the number of hemodialysis catheters. A primary goal of the Network is to lower the proportion of hemodialysis patients dialyzing via catheter to the K/DOQI recommendation of < 10%. Facility staff will be encouraged to address the assessment of patients with catheters as the primary access for >90 days. The activity will consist of mailouts included in the Fistula First materials that will be going to facilities. These will include algorithms for catheter assessment and referral, patient educational videos and root cause analysis information with suggested interventions. Research on successful interventions in other Networks was done in late 2003 including identification of resources that we intend to use. At the end of 2003, the project proposal was awaiting review by the MRB Project Review Committee.

Albumin

Goal: 35% of patients with mean albumin \geq 4.0/3.7, Network 8 performance: 36% (again 36% in 2002), US: 36%, Target performance: 35%

The MRB chose to make this the first QI activity conducted under the Network Quality Work Plan. Focusing on albumin improvement, the objective of this activity was to identify best practices to improving albumin values in the Network region and to share this information with low performers. A short questionnaire was developed and sent to nine of the best performing facilities in the Network

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area who had albumin values above the national norm. Data was collected regarding their policies and procedures. We then asked the low performers to send us their policies and procedures. The MRB reviewed the results and concluded that many of the facilities had written protocols in place to address the problem of low albumin, had undertaken an improvement activity and that the physicians and dietitian were aggressively educating patients about diet. The activity was then concluded.

Additionally, patient educational materials addressing this topic were handed out at patient meetings and speakers did address this topic during the meetings. Elab reports back to facilities were also used to address the issue along with certificates that were given out at the annual meeting recognized facilities that met all of the CPM thresholds.

Adequacy

Goal: 80% of patients with a URR \geq 65, Network 8 performance: 84% (up to 87% in 2002), US: 84%, Target performance: 80%

Our Network continued to be one of the top performers in the US for adequacy. We did continue to promote improved adequacy in our access related educational offerings since the two are so related. Education for patients and their families were given out at patient meetings. Elab reports back to facilities were also used to address the issue. Additionally certificates that were given out at the annual meeting recognized facilities that met all of the CPM thresholds.

Anemia

Goal: 70% population with Hgb \geq 11, Network 8 performance: 73% (up to 76% in 2002), US: 76%, Target performance: 70%

We will continue to offer patient educational materials at patient meetings and explore opportunities to collaborate with others on educational projects. Elab reports back to facilities were also used to address the issue. Also certificates that were given out at the annual meeting recognized facilities that met all of the CPM thresholds.

Educational Initiatives

2003 Annual Network Council Meeting

The 2003 Annual Network Council Meeting was held at the Wynfrey Hotel in Birmingham, Alabama, September 17-19. The meeting theme was "Creating a Safer, Smarter ESRD Environment". More than 285 registrants and 28 exhibitors attended the meeting. The audience included nephrologists, nurses, social workers, dietitians, renal administrators, PAs and PCTs.

Pre-meeting events on Wednesday included a workshop sponsored and produced by two pharmaceutical companies. Topics covered included principles to enhance patient education and the relationship of cardiovascular disease to renal osteodystrophy. A data workshop by the Network staff and reception followed.

The meeting was opened on Thursday morning by Cindy Powers, Network Council Chairman. Educational sessions included presentations on hemodialysis adequacy, removing barriers to transplantation, quality of life issues and infection control issues. Afternoon breakout sessions for clinicians, dietitians and social workers were held. Clinical topics included ESRD assessment, staff shortages, and problems associated with hemodialysis catheters. Psychosocial sessions included presentations on the depressed patient, relationship problems, and vocational rehab. Nutritional sessions included Levo-Carnitine applications, control of diabetes in the dialysis patient, and a dinner session on iron deficiency sponsored by a pharmaceutical company.

All audiences reconvened Friday morning for joint sessions on the National Involuntary Patient Discharge Survey 2002, state survey survival, and presentations on professional ethics and boundaries and work-place priorities.

The meeting concluded with the completion of evaluation forms, the presentation of the re-elected Network Council officers and the announcement of the next meeting date and location. Overall meeting evaluations were positive and suggestions were included for future presentation topics.

Facility Newsletter

Two editions of *Network News* were published in 2003 and distributed to facilities and medical directors. Topics included announcement of the Fistula First project, data department news, discussion of the patient grievance process, influenza protection advice, and how to obtain technical assistance.

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Patient-centered activities and resources

PAC Meetings

Network 8 held three Fall Patient Advisory Council (PAC) meetings in 2003. These were the traditional day-long educational seminars with one meeting begin held in each of our three states.

The Mississippi meeting was a joint meeting with the NKF of Mississippi. Approximately 100 patients and family members attended the meeting which was held at the Hilton Hotel in Jackson on August 24, 2003. Dr. John Bower delivered the opening address which was a history of kidney disease, past, present and future. Gaye Ragland, a local nurse educator also delivered a very inspirational presentation on empowerment. Other topics included a panel presentation on the complications of ESRD, a session on the benefits of exercise, a patient panel discussion on the advantages of employment and if it can benefit all patients and, in keeping with our Fistula First project, a session by a local nephrologist on why fistulas are the best option. All of the sessions were rated very good or excellent by the attendees.

The Alabama meeting was a joint meeting with the Alabama Kidney Foundation. Approximately 125 patients and family members attended the meeting which was held at the Birmingham Marriott Grandview Corporate Park on October 12, 2003. Kenneth P. Moritsugu, M.D., M.P.H. was the keynote presenter. Dr. Moritsugu has spoken to many groups on organ donation having donated the organs of two of his family member. Many other topics were covered including skin disease, living kidney donation, ESRD in the minority community, long term health issues for transplant patients, insurance, understanding the transplant waiting list, legislative issues, transplant medications, and once again, why fistulas are the best option. The "Lunch With the Experts" was held again and was extremely popular. The overall evaluations were excellent.

The Tennessee meeting was held on October 26, 2003 at the Embassy Suites hotel in Nashville, TN. The meeting was a joint meeting with the Middle Tennessee Chapter of the American Association of Kidney Patients. Kris Robinson, the Executive Director of AAKP and an 18-year transplant recipient was the keynote speaker. Other topics discussed were sleep disorders in ESRD patients, a patient panel discussion on the importance of self-care, exercise, a wonderful slide show of a grocery store shopping tour, and of course, the advantages of fistulas. Approximately 70 patients and family members attended the meeting. The evaluations were very positive.

Transplant Advisory Committee (TAC)

During 2003, the Transplant Advisory Committee (TAC) continued the activities that were begun in 2002. The transplant poster was completed and sent to the RO for approval in early May and the poster was sent to the printers. They were received here in the Network office in mid-May and went out to the facilities on May 26, 2003. Following the initial dissemination, we have received many additional requests for the posters and gave approximately 80 posters out at our annual meeting. Additionally we heard from several networks that they would like to collaborate with us and use the art from our poster to do their own transplant poster. We subsequently collaborated with Network 6, allowing them to use our artwork and we did receive a copy of their completed poster. We also have been in contact with one other Network.

Also in 2003, work was begun on the analysis of the transplant status information collected from all the dialysis facilities in the Network area. Frequencies were done on patient status: (1) Medically unsuitable, (2) Refuses, (3) Referred, (4) Waiting and (5) Not evaluated. We looked at the referral patterns of dialysis facilities along with the strongest indicators for why patients weren't referred. We did receive word from our TAC chair in mid-September that he had looked at the tables and that they should be frequency table to the TAC committee. This was done in October. Following this dissemination, questions were raised by the committee members regarding the interpretation of the data. This led to the discovery of a coding error for race and an unexplained censoring of patients under the age of 40. There were discrepancies among the three states in reporting consistency and so much data for Mississippi was missing that the analysis could not have been done with confidence. Subsequently work was halted until a new dataset can be drawn and data quality checks put in place before submitting the data to the committee. Under the terms of the new contract, we will also ask the committee to help us structure the work that we hope to accomplish with this data, the goals of the project and the intervention to make sure that this project does not need IRB approval.

The PSC now serves as the Region 3 representative to the Patient Affairs Committee of UNOS (United Network of Organ Sharing). This committee met in Chicago on September 29 – 30, 2003. UNOS will pay all expenses to these meetings and the Region 3 meetings.

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. Ellie is also President of the Middle Tennessee Chapter of AAKP.

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The AAKP convention was held in New Orleans, LA from August 28 – 31, 2003. Network 8 again sponsored its three PAC chairs (from Mississippi, Alabama and Tennessee) to the convention. The Alabama chair was not able to attend, but the vice-chair was able to make the meeting. Ellie Durrett served on the convention committee and Ellie also was one of three featured patients that helped kick off AAKP's new awareness campaign...."AAKP Says I Can"....This campaign which was unveiled during convention will help dispel the myth that dialysis patients can't lead normal lives. AAKP's new Chronic Kidney Disease educational book was also unveiled at convention. It is currently available free of charge to anyone who is interested in obtaining the book for the CKD population. During this year's convention, Dr. John Bower of Network 8's BOD received the Visionary Award for his work with CKD patients. Dr. Bower is currently co-chair for the Jackson MS pilot site of NKDEP. Additionally, Dr. Paul McGinnis, of the Network 8 MRB was a presenter at this convention, moderating a panel discussion on "Dealing with the Emotional Impact of Kidney Disease".

Network 8, along with AAKP and Ortho-Biotech presented a Chronic Kidney Disease Program, "Finding Your Strength" on September 27 in Jackson at the Jackson Hilton. The meeting was presented in Jackson as part of the NKDEP pilot program. Approximately 55 people at risk for kidney disease came to the meeting, enjoyed the presentation and had their hemoglobin screened. Another "Finding Your Strength" program was held in Nashville on April 12. The PSC presented at this meeting representing AAKP and Network 8.

At the AAKP Medal of Excellence Award Ceremony in Washington, D.C., held in conjunction with the RPA meeting, the PSC presided over the Award Ceremony. 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 continued to serve on the Forum QI CPM committee as the representative of AAKP for part of 2003 and then rotated off the committee. The PSC also represented AAKP on an ESRD CAHPS Technical Expert Panel Meeting regarding Patient Satisfaction Surveys that was held on June 3 in Arlington, VA. She attended the ASN meeting in San Diego, November 13 – 16 as AAKP's representative.

October 2 – 3, 2003, the PSC represented AAKP and Network 8 at a Consensus Conference in St. Louis which was conducted to design a Collaborative Action Plan for addressing Dialysis Patient – Provider Conflict. She has since participated in the follow-up to the conference by rating certain issues that arose as potential problems and interventions. A Forum sponsored meeting of all of the Network's Patient Services Coordinators was held jointly with the conference. The PSC's are working on a tool kit to aid in the handling of complaints.

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NKF

The Patient Services Coordinator continues to collaborate with the National Kidney Foundation in several initiatives. The PSC attended the first organizational meeting of the Mississippi Transplant Team on November 2 to begin preparation for the 2004 U.S. Transplant Games which will be held in Minneapolis, Minnesota, in July of 2004. Possible fundraising opportunities were discussed. The PSC is a member of the team and has previously served as Team Captain and as twice as Team Manager.

Both the PSC and QIC continue to serve on the NKF of Mississippi's Professional Advisory Board. Efforts of the Board have included the NKF of Mississippi's cookbook, a program to provide emergency funds to dialysis patients in Mississippi, a program to provide nutritional supplements to dialysis patients and several patient educational programs. Among these programs is the Forward Bound Vocational Retreat for young people with kidney disease. This year, the retreat was held at a local state park on November 8 – 9. This retreat teaches young ESRD patients interview skills, how to fill out questionnaires and helps them deal with emotional and psychological issues. The PSC served as a peer counselor for this retreat as she has done numerous times in the past. Fifteen young people graduated from this program in November.

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 for People Like Us Live and RISE workshops 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 January and April of 2003. She also spoke at a local area church in February 2003 along with her sister on organ donation.

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. Several screenings were held in 2003 including screenings on March 27, April 3, August 22, September 6, October 22, and December 13. Several of these screenings were also used to promote NKDEP materials.

National Kidney Disease Education Program (NKDEP)

Jackson, Mississippi, was chosen as one of four pilot sites for the National Kidney Disease Education Program (NKDEP), which will target and educate high risk groups for prevention of kidney disease. Other pilot sites are Atlanta, Cleveland and Baltimore. Following organizational meetings in 2002, the project got underway in 2003. The PSC, QIC and ED serve on the Steering Committee and the PSC was named a co-chair for the pilot along with Dr. John Bower and Lynda Richard of the NKF of Mississippi. A meeting was held in January to approve the strategic plan for the coalition and another meeting was held on March 5 in the Network 8 conference room to conduct media training for coalition members chosen to act as media spokespersons for the initiative. The PSC and QIC attended the session. The kickoff for the Jackson pilot was held on April 26 in conjunction with a minority health fair at the Jackson Medical Mall. Additionally the PSC represented NKDEP at a Diabetic Health Fair on June 14 and other steering committee members began distributing material at local church health fairs.

The PSC represented NKDEP at a meeting of all four pilot sites that was held in Washington on June 20 to discuss what the Jackson group had implemented and how the implementation was going on. Following the meeting, the PSC worked diligently to get the word out on the project. She was able to arrange a front page article in the State's largest newspaper along with a feature on one news channel and an announcement on another. Additionally four KEEP screenings were held in the Fall which incorporated NKDEP materials and ran the educational video asking participants to fill out evaluations on the video. The video was shown and materials were given out at the Mississippi PAC meeting and the AAKP "Finding Your Strength" Program was incorporated into NKDEP and again materials were given out at the program.

Other Fall activities included handing out brochures at the Kidney Walk sponsored by NKF of Mississippi and at the Mississippi Organ Recovery Agency booth at the Mississippi State Fair. NKDEP had a booth at the Health Disparities Conference which was sponsored by Jackson State University and two presenters at the conference, Dr. Keith Norris and Dr. John Bower spoke extensively regarding NKDEP. The Mississippi QIO newsletter which goes to all the physicians in the state, contained an article about NKDEP based on materials supplied by Network 8 and the NKF of Mississippi patient newsletter and professional newsletter also contained articles. At year's end, several additional activities were planned for 2004. The project is scheduled to end in May of 2004 and is going to be taken nationwide in June, 2004. A pre-test that was given to at risk individuals prior to the pilot showed a definite lack of education and knowledge regarding kidney disease in the Jackson area. A post-test is scheduled to be given following the conclusion of the pilot.

Educational media for patients

The Network's patient newsletter, *Kidney Patient Update*, was distributed twice in 2003. The Spring edition of the patient newsletter was sent to providers in March, 2003. It included articles on compliance and disaster preparedness along with the continuing features "The Doctor Is In" and "The 20 Year Club". The Fall/Winter Issue of the newsletter was sent to facilities in December. It included articles on rehabilitation, influenza vaccinations, and vascular access and the Fistula First Initiative. It included a contest for patients to write essays describing why they love their fistula. The results of the contest along with the winning essays will be published in the Spring, 2004 newsletter.

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. This project will be completed in 2004.

Additionally, the transplant poster was distributed to all dialysis facilities in 2003.

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.

In early 2003, the PSC contacted each state VR agency in an effort to provide an in-service to their counselors regarding the unique needs of the ESRD population. This was following the distribution of the IRI-produced publication that was created as a resource for training VR counselors and distributed by LORAC in the Fall of 2002. Following discussions with the VR agencies, it was determined that the most cost effective way of meeting the needs of the VR counselors was for Network 8 to present at the states VR annual meetings. We

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then received invitations to present at two of these meetings (we were never able to make a meaningful contact with the Tennessee Agency). On June 19, 2003, Network 8 staff along with a local renal social worker presented at the Alabama State Rehabilitation meeting in Tuscaloosa. Additionally, Network staff, along with another social worker and a patient panel which included the PSC, presented to the Mississippi Rehabilitation Meeting in Jackson, MS on August 14. We received several offers to speak at additional meetings including a Regional multi-state meeting that will be held on the Mississippi Gulf Coast in 2004. These had also been sent directly to each State VR agency.

Examples of educational materials supplied to patients or facilities

- Network 11 Patient Education 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

Other Technical Assistance to Providers/Facilities

Assistance is provided on an ongoing basis for help with clinical matters (by either direct consultation or referral); with CMS forms completion; and with interpretation of questions on CMS, USRDS, and CDC surveys.

Other Activities Related to Improving the Quality of Care

USRDS Special Studies

Five studies have been contracted 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 large chains imposed a moratorium on their staff with regards to completing the forms for the deceased patients. Because of this issue only about 60% of Network 8's forms that were sent out for deceased patients were returned to the Network 8 office. We were told by CMS not to press the issue so we did not remind the facilities or push them to complete the forms. 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 give 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.

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CMS also asked each Network to submit an estimated budget for travel to and from the facilities where the living patients are located. The expectation is that we will also abstract the forms for any expired patients included in the study who were dialyzing at the facility (where the patients are receiving treatment) at the time of their death. The estimated budget was completed and submitted to CMS on November 25, 2003.

The Network was then notified that USRDS would like to include more patients and asked each Network for an addendum to the travel budget that would include expired patients living in a 60-mile radius of the Network office. This is due to CMS by January 9, 2004. CMS will then negotiate with the Networks until the budget is acceptable. CMS will pay 36 center per mile, hotel costs and \$50/completed form.

Network staff will then begin to travel to the facilities included in the study and abstract the data for any living patients and any expired patients whose charts are retrievable. The actual travel and abstraction of records hopefully will begin in early 2004.

Following the completion of the Cardiovascular study, the Network will await word on when the Comprehensive Dialysis Study will get underway.

CDC Data Collection

For the second year, 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 to Networks, leading to extensions in the date forms were due to each Network office.

Selected entry of vascular access was done to accommodate an important kick-off NVAII conference in June 2003. This entry and subsequent Network-area aggregations made it possible for CMS to present a baseline comparison of regions so that improvement targets could be anticipated.

Following that exercise, the remainder of data elements were keyed, and the database was transferred to CDC where extensive analysis began. When CDC returned the database, Networks were given a final opportunity to retrieve missing data and query discrepant data.

During that time, staffing changes at Network 8 contributed to additional delays, and additional work was undertaken to verify the accuracy of queries underlying output reports. At the end of the year, quality checks were ongoing to promote data accuracy and completeness, and the target date report release was set for

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the first quarter in 2004. Profiles developed in 2003 included vascular access, hepatitis B and C prevalence and vaccination rates, and HIV and VRE rates.

CPM Data Collection for CMS

The CMS CPM forms were received by each Network during the month of April 2003. These forms included the Hemodialysis sample, the Peritoneal dialysis sample, the Facility survey forms, the Pediatric forms and the VHA forms. 100% of the pediatric population and 100% of the VHA population was surveyed using the form. The forms were sent to facilities on April and due back to the Network office by May 16. Many of these forms had not been returned and we had to call facilities to assist in their completion. The forms were originally scheduled to be entered into VISION and sent on to NW 9.10 on June 13. Because of issues with the VISION software, this was delayed until July 11. The VHA forms were due in hardcopy on June 23 and these were all received and sent to 9/10 on June 18.

Data validation was completed on all of the selected charts, entered into VISION and sent on to Network 9/10 before the deadline date of October 2.

LEAP Projects

The Collaboration between Network 8 and the Tennessee QIO on the LEAP (Lower Extremity Amputation Project) Project came to a successful conclusion at the end of 2002. The goal of the project was to reduce amputations in the diabetic ESRD population.

Network 8 also partnered with the American Diabetes Association and the Mississippi Department of Health on a Mississippi-based LEAP initiative. This program was also designed to reduce amputations in the diabetic ESRD population. In early 2003, the LEAP organizers informed us that they did not receive additional funding for the year 2003 and that the initiative had been concluded.

AQAF – Patient Safety

Following termination of the AQAF Patient Safety Project, AQAF and Network 8 jointly worked on the language for a letter to send to the 11 project facilities. The letter was mailed to the facilities, the steering committee and other interested parties.

Additionally, the diskette containing the materials developed by this project was reproduced with permission and sent to all other Networks.

Prescription Continuity of Care (PCCS)

Network 8 met in September with the Mississippi QIO, IQH – Information and Quality Healthcare, regarding the Prescription Continuity of Care System (PCCS). IQH then followed up with a request that the Network share a patient-specific Elab database with them. The primary MRB concern in handing over the data was whether there was the potential for intervention by IQH or others at the patient or facility level. Intervention would trigger the need for informed consent from the entire group of patients named in the Elab database. A number of conversations and email communications transpired between Network 8 and IQH and between Network 8 and CMS before the matter was clarified. The matter moved forward when it was learned that an IRB approval for the project had been obtained by the University of Mississippi School of Pharmacy, exempting the project from informed consent, and when a data use agreement was developed that clarified that there was no plan for intervention. Following the signing of the data use agreement and approval by the Regional Office, the dataset was delivered to IQH in late 2003.

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. Newly diagnosed patients are informed of their right to contact the Network or state agency to voice their concerns.

The Network continues 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.

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 (2000- 2003). The contacts were classified according to the definitions and coding by CMS.

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SIMS CONTACT SUMMARY				
Historical Overview: 2000-2003				
Category	CY 2000	CY 2001	CY 2002	CY 2003
Grievances	0	0	0	0
Complaints	14	22	15	28
Beneficiary Inquiry	8	9	5	59
Facility Concerns	14	54	63	66
Facility Inquiry	10	30	103	104

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 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 of behavioral). **Facility inquiry** is request (from staff) for information, advice, referral, or educational material that doesn't require problem resolution.

In 2003, the Network 8 staff received and processed 257 patient related contacts ranging from beneficiary complaints to simple requests for basic educational materials. The Network did not receive a formal grievance during 2003.

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 2003. 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.

Contacts received at the Network were classified according to CMS definition. Below is a summary of the contacts that were received during calendar year 2003.

Formal Grievances: All patient concerns were classified as “complaints” during 2003.

Beneficiary Complaints: 28 Opened --- 28 Closed

In most cases, Beneficiary Complaints focused on issues in which the Network mediated between patient and staff. Most concerns arose due to a lack of communication or miscommunication between patients and staff. Many contacts involved issues addressing staffing shortages and training of new staff. In response, Network staff contacted the Administrator, Director of Nursing or

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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, 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: 59 Opened --- 59 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 with finding transient dialysis, and concern about facility requirement for transient dialysis or cancellation of transient dialysis after initial acceptance.

Facility Concerns: 66 Opened --- 66 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.

Facility Inquires: 104 Opened --- 104 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.

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

A. Hardware and software infrastructure

The foundation of efforts to improve data quality is based on a uniform architecture specified by CMS. For calendar year 2003, all computer hardware utilized by Network 8, Inc., as well as CMS-leased equipment, met or exceeded minimum CMS requirements.

Prior to 2003, Network 8, Inc. operated a Novell local area network with a Dell file server and Dell user workstations supplied by CMS. A separate CMS-supplied Compaq server housed all SIMS files and was accessible on the LAN.

In 2003, CMS adopted a uniform Windows 2000 architecture for all ESRD Network organizations as part of its CROWN system, and high capacity Dell servers were provided under lease to each organization. During the course of the year, staff were trained in the use of the new operating system with special attention to the expanded security requirements resulting from the change. Benefits of the upgrade include uniform hardware and software across the wide area network and consolidation of servers within each office. (The Compaq server used in the initial rollout of SIMS was taken offline and donated to an educational charity under CMS guidelines.)

As with the prior system, user workstations have access to a shared hard drive and shared software. All user workstations are connected to the new server for access to patient, facility, and Network data. This server, router, switch, and CSU/DSU interface with a robust T-1 line to provide WAN connectivity to CMS and to other Networks.

Battery-back-up devices reduce power interruptions for both the file servers and the desktop units. An internal tape back up unit the new 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.

SIMS uses a daily transmission called replication to routinely transfer local database information to the Central Repository in Baltimore, Maryland.

B. Custom Data Capabilities

An internal software module (Net8Ware) has been created by the ISD and is maintained for additional data analysis. This is in addition to the reporting that SIMS provides. This data system is capable of producing a wide array of tables, graphs, and charts for profile analysis by the MRB and for processing data

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requests. It assists in mining data from the SIMS database and creating useful reports and analyses for the Network Data Systems staff.

C. Data Security

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 nightly by an automated tape back-up device. This system operates after hours, preventing daily system down time. A full system back-up is performed on a nightly basis and stored off-site in a bank vault on a weekly basis. The Network office is equipped with a monitored burglar, smoke, and fire alarm system.

D. Data Requests and HCFA-Forms Processing

CMS Forms		
	HCFA 2728	HCFA 2746
2003	5305	3838
2002	5237	3685

During the 2003 calendar year, Network 8's Data Systems staff processed 9143 CMS Forms. These forms included 5,305 CMS 2728 forms and 3,838 CMS 2746 forms. The number of CMS 2728 forms may not match the number of incident cases in 2002 because the number referenced above includes forms received in 2003 for 2002. The above referenced number also excludes 2003 forms received in 2004, and accounts for 2003 forms received, entered, and submitted to CMS for patients later determined to be acute.

All data transmissions and forms submittals were provided to CMS by the Central Repository. CMS is able to pull the 2728 file for this transmission. This process ensures that all replications accurately communicated the data from the local Network to the Central Repository.

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E. Accretions, data element changes, and notifications

The Network received 12,937 monthly reports with Accretions, Data Element Changes, and Notifications that were processed against SIMS. The Network office processed 13 requests for data in accordance with Federal guidelines for release of data. A file is maintained in the Network of all data requests.

	Accretions DEC and Notifications	Medicare +CHOICE Requests	Data Requests
2003	12,937	457	13
2002	27,647	377	113

F. Monitoring Facility Compliance with CMS Forms

Form compliance is calculated using CMS timeliness and accuracy guidelines. To help facilities correct individual compliance problems, forms returned for correction include a description of the error(s). Forms that are missing (detected by a mismatch in data from the Network's Monthly Census Report) are queried every quarter. Special emphasis is given at year-end to obtain CMS forms that have not been submitted during previous queries.

G. CPM Data Validation

The CMS CPM data validation sample was selected by CMS and received in the Spring of 2003 along with the CPM sample. Following the completion of data entry of the CPM forms, the requests for facilities to copy records for CPM data validation were sent out. We then received the copied charts for all thirty-two patients that were selected for data validation. These records were abstracted by QI staff and entered into VISION by the data department and sent electronically to NW 9/10 before the October 2, 2003 deadline.

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)

Alabama Quality Assurance Foundation (AQAF)

As summarized in last year's report, Network 8 and AQAF partnered to pilot the nation's first regional ESRD patient safety project. The project began in February 2002 and continued through November, 2002 when it was discontinued due to lack of funding. In January 2003, Network 8 assisted AQAF in producing a letter that was sent to the 11 project facilities, the steering committee, and other interested parties expressing gratitude for their help in pioneering this project.

Although the project was discontinued, the time and effort of the participants facilitated development of various patient safety training tools. These included an event management-training manual, an event reporting form, and various safety awareness materials.

AQAF released all of the materials to Network 8 in disk format, and these were reproduced with permission and distributed to all Network organizations in January, 2003.

Information and Quality Healthcare (IQH) – Mississippi QIO

For information on the PCCS project 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.

Qsource—Center for Healthcare Quality – Tennessee QIO

For information on the LEAP project see summary under Other Activities Related to Improving Quality of Care

State Survey Agency Partnerships

The Network continued to strive toward maintaining working relationships with the three survey agencies (SA) as well as the state Quality Improvement

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Organizations (QIOs). Informal communication was utilized for problem solving, sharing of information or requests for assistance.

The Network remains committed to sharing reports and materials as much as possible with all our cooperative partners.

The following examples illustrate Network and state agency (SA) collaboration and referral in 2003:

Alabama

- The Network contacted the SA after a report regarding the facility's unsanitary environment.

Mississippi

- Before a scheduled survey visit to a facility, the SA contacted the Network to determine whether prior deficiencies had been cited or if the Network had concerns regarding the facility.
- The surveyor cited a care plan issue and requested that all patient care plans include input from each discipline.

Tennessee

- The Network contacted the SA after a family member called with concerns about inappropriate observance of infection control measures.
- The surveyor contacted the Network regarding a facility's deficiencies that represented a serious threat to patient health and safety.

Partnerships with ESRD Facilities

Birmingham Project

This locally developed project created a protocol to guide decision-making when patient placements are in jeopardy. Lessons learned in the project have been utilized in guiding other facilities in their approaches to placement planning.

Partnerships with Other Networks –

Patient Education

The artwork for the Network 8 transplant poster was shared with Network 6 during 2003. We have also received requests from other Networks to use this artwork.

ELAB

See summary under Quality Improvement Projects and Activities.

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Fistula First

Network 8 collaborated with all Networks in the development of Fistula First strategies. Because of a unique collaboration with CMS and the other Networks, Network 8 was able to perform data entry of CDC data and produce prevalent vascular access rates for each Network region for use in local planning.

Network 13 invited Network 8 facilities to their Vascular Access Conference in October 2003, in Kenner, Louisiana. Network 8 staff mailed conference brochures to facilities in this region, and staff, board members and vascular access project workgroup attended the conference under Network 8 sponsorship. Collaboration with Network 13 continued following the meeting to develop speaker resources and to deploy lessons learned in vascular access workshops.

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 ANNA organization as well as local chapters within our network.

AAKP – During the past year, the PSC continued to be actively involved with the American Association of Kidney Patients, 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. 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. During calendar year 2003 the updated Life Options Employment book was completed. The PSC was interviewed for this book and was featured as a working patient.

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”.*

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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 background of a modernized data infrastructure for the ESRD program is described succinctly on the CMS website:

CMS and the ESRD Networks are working together to build an integrated ESRD information system called Consolidated Renal Operations in a Web-enabled Network (CROWN). CROWN will facilitate the collection and maintenance of information about the Medicare ESRD program, its beneficiaries and the services provided to them. Maintenance of this information by CMS is mandated by legislation and regulation. (See Public Law 95-292, Section (c)(1)(A); 42 CFR [Code of Federal Regulations], Chapter IV, Part 476; and Public Law 92-603, Section 299I.)

We expect to modernize the collection and retrieval of ESRD data in a secure, Web-enabled environment. The new capabilities will allow dialysis facilities to enter information electronically and transmit it to the appropriate ESRD Network, and CMS also will be able to send feedback to the Networks and the facilities through the new environment. (www.cms.hhs.gov/esrd/7a.asp)

The three components of CROWN include:

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

Together these components are designed to enable electronic exchange and validation of data, facilitating the transformation of data into usable information.

VISION

Network beta testers, including Network 8, completed their roles as beta testers for CMS in 2002 for the VISION pilot project. CMS announced a dual software development strategy: creation of a corporate-level interface to use with the large dialysis organizations and production of a standalone, PC-based version of the software for independents and small chains. The Network role would be to offer the standalone version to eligible facilities.

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By December 2003 Network 8 had enrolled 10 clinics in the VISION project. Training was conducted and the clinics, through a centralized data coordinator, were given on-site technical help in achieving the capacity to participate in the project. When it was announced that an improved version of the software would be released in 2004, the decision was made to wait for that version before proceeding with data transmission. The goal for 2004 will be full implementation of VISION for these 10 clinics and increased marketing to, training, and participation of additional clinics.

SIMS

SIMS is an integrated system that provides communication and data exchange links among the Networks, the facilities, and CMS. Each ESRD Network has a local database in which patients are registered and critical information is updated and stored. This information is replicated routinely to a central repository.

SIMS produces national and local prevalent patient rosters to list the patients and the events for a given year. SIMS also produces 2744 forms. Facilities are given these forms to use as an aid 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.

SIMS provides a summary of key events in ESRD patient history, including all changes in modality, setting, and provider. SIMS includes the capability of producing data compliance reports called for in the scope of work. During the course of the year, the Network performed routine hardware and software maintenance functions to assure the security and functionality of the local SIMS architecture.

REMIS

A key component of CROWN is the Renal Management Information System. Data from multiple sources flows to CMS, and ESRD Networks are able to use this feature, in many cases, to resolve discrepancies in demographic data without having to call on dialysis or transplant facility staff to verify the information. Event histories can be gleaned from billing data, allowing the Network to round out patient event histories. Networks often are able to discover data provided from sources such as Social Security that allows the resolution of chronological histories. Data verified independently by Networks is an integral component of REMIS, and internal processes are continuously undertaken to assure that stored data is as accurate as possible.

SANCTION RECOMMENDATIONS

Network 8, Inc. did not initiate sanctions against any facilities during 2003 for failure to cooperate with Network or CMS goals.

RECOMMENDATIONS FOR ADDITIONAL FACILITIES

No recommendations for additional facilities are made at this time. Each year, dialysis companies assess the generation rate of new cases, and there have been incremental expansions over time. Most regions, including rural communities, are served by one or more facilities within a short driving distance.

DATA TABLES

The tables on the following pages were created to CMS specifications, and most of the displays depict information as of December 31, 2003.

Tables include all Medicare-approved Network 8 facilities, as well as four VA facilities. Data in the tables were validated by a process which reconciled annual survey totals with a patient event roster generated from SIMS. Substantial work was performed by providers in transmitting and validating information represented on these pages.