

2004 DIALYSIS FACILITY REPORTS DISTRIBUTED

By now you should have received your 2004 Dialysis Facility Reports (DFR), prepared by the University of Michigan Kidney Epidemiology and Cost Center (UMKECC).

The purposes of the report are listed below:

- To notify you of your facility's updated quality measures that will be posted on the Dialysis Facility Compare (DFC) website in November 2004 and to provide instructions for submitting comments to CMS about your DFC measures.
- To notify you that your 2004 Dialysis Facility Report will be sent to your State Survey Agency (SSA) in October 2004 for the State's use in survey activities and to provide instructions for submitting comments about your entire report. Your comments will be appended to your Report before it is sent to your SSA.
- As a tool that you can use in your facility's quality improvement activities and to provide instructions for submitting general comments to UMKECC about your report.

The statistical analysis for the information provided in this Report was conducted by the University of Michigan Kidney Epidemiology and Cost Center (UMKECC) with funding from the Centers for Medicare & Medicaid Services (CMS).

The Report is based on data from Medicare dialysis and hospitalization claims, Medical Evidence Forms (CMS-2728), Death Notification Forms (CMS-2745), Annual Facility Survey Reports (CMS-2744), other CMS data and Social Security Administration data. Generally the information in the reports is for the time period January 2000 - December 2003.

WHO'S ON FIRST?

A number of staff changes have occurred at the Network office over the past year or so that we want you to know about. In the QI department, Ann Pridgen assumed the QI Director position in July 2003, and Sheila Mitchell was hired this June as QI Coordinator.

In the Data Department, Judy Carter was hired as Data Manager/IS Director in March. Others in that department are Katie Wilcher, April Freeman, and Janet Henn (Janet joined us in August 2003), who serve as Data Specialists respectively for Alabama, Mississippi, and Tennessee.

Brenda Dyson wears two hats as Patient Services Coordinator and Special Studies Coordinator (primarily CPMs and Elab). Sylvia Catchings, serves as Office Manager and front-line telephone receptionist to our customers, and Jerry Fuller, is Executive Director. Dyson, Catchings, and Fuller have served on staff since the inception of Network 8 in 1988.

Cathy Hartzog serves as a consultant to the Network for activities related to the annual educational meeting.

It is our common goal to work collaboratively with you in support of your quality improvement efforts and provide technical guidance with respect to specific CMS compliance issues. We welcome your feedback on ways we can better achieve these objectives.

IVAN TESTS EMERGENCY RESPONSE

Hurricane Ivan proved to be a major inconvenience for a number of renal patients and providers in the Network 8 region, but advance planning by facilities and their corporate organizations helped reduce the severity of disruptions.

Alabama had the greatest number of facilities knocked offline due to power outages. That was an expected problem which was made less severe by the doubling up of treatment schedules the day before landfall. The dislocations were further minimized by the

presence of on-site generator capacity in a number of Mobile-area facilities.

All dialysis corporations announced an open-door policy for patients of affected units, and this was particularly helpful for patients who evacuated coastal areas and were unable to return to their home facilities. At press time there were only few facilities that were still using generator power, but for several days after Ivan, many units were closed and others could run only partial caseloads because of the limited generator capacity.

The Network served as a conduit of information between the state survey agencies and CMS and between individual facilities and CMS. Network 8 also provided the three state emergency management agencies with contact information for the Network and toll-free "travel line" numbers that large dialysis organizations had given us to disseminate to help in locating treatment facilities for patients. The EMAs were also provided with your facility's name, location, and contact information with a request for priority power and water restoration.

Based on reports from the field, all Network 8 patients were taken care of, as well as some from Florida and Louisiana. Those on the front lines have worked tirelessly during this period, some without power themselves. We commend all of you for pulling together and working non-stop to take care of patients before, during, and in the aftermath of Hurricane Ivan.

ONGOING NETWORK SERVICES

Facilities with questions ranging from quality of care issues to forms processing should call us at 601-936-9260. We will do our best to help you or see to it that you are referred to a source of information for your technical assistance needs.

Patients with complaints or concerns may contact the Network by using the patients-only toll-free number: 877-936-9260. We recommend that patients first work with you directly to resolve their concerns, but we are available for first-line contact when that is the patient's preference.

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NETWORK NEWS

SERVING RENAL PROFESSIONALS IN ALABAMA, MISSISSIPPI AND TENNESSEE

FALL 2004

UPDATE ON OCTOBER MEETING IN MEMPHIS

Preparations are in high gear for the annual meeting in Memphis, which will inaugurate a new meeting schedule as well as a separate track for physicians. Here is the schedule of activities:

Thursday

Nurses and techs may sign up for a special session from 1:00- 4:00 p.m. led by national vascular access expert Debbie Brouwer. Session cost is \$30.

Registrants of all disciplines are invited to the wine and cheese social from 5:00-6:30 p.m.

A complimentary, Amgen-sponsored dinner is available to nurses, dietitians, and physicians who pre-register by mail or by calling 800-232-9997.

Friday

Physicians are invited to attend a Fistula First track from 8:00 am until 4:00 p.m.,

and the panel of nationally known speakers is led by NVAII clinical chair Larry Spergel, MD. The fee is \$150, and it is waived for residents and fellows.

A separate track of multidisciplinary clinical sessions is available for nurses, techs, dietitians, social workers, and administrators from 8:00 a.m. until 3:45 p.m. with a fee of \$100.

Credits for all disciplines have been applied for through the appropriate credentialing centers: the American Nephrology Nurses Association (ANNA), the National Commission on Dietetic Registration and the National Association of Social Workers. To date we have received approval for 6 contact hours for the dietitians.

Although restrictions imposed by the credentialing authority prevent us from discussing the status of physician credits here, see our official meeting brochure at <http://www.esrdnetworks.org/networks/net8/net8.htm> for more information. Registration and other meeting information can also be found in the brochure.

MEDICATION PROJECT INITIATED

On July 30, 2004, Network 8, Inc. was awarded a contract from CMS for a one-year ESRD Outpatient Medications Project, which will assist in the implementation of the Medicare Modernization Act (MMA) Part D prescription drug program.

Working with the University of Mississippi School of Pharmacy and a panel of twelve experts, Network 8 will retrieve and analyze national data on medication usage by ESRD patients. Baseline data analysis will be distributed to members of the renal community for review and comment. When the project is completed in June 2005, a final report and presentation will be given to CMS in Baltimore which will address demographic profiles, medication prevalence, drug classes specific to ESRD patients and drugs not recommended for ESRD patients. Additionally, the report will include proposed ESRD drug utilization review criteria and proposals for further areas of investigation.

Updates on this important project will be presented periodically in this newsletter and/or the Network 8 website.

VISION-NEW AND IMPROVED

New glasses for everybody?? Not quite. Just a new way to look at forms transmission for clinics not affiliated with a Large Dialysis Organization (LDO).

After a brief intermission while CMS improved the software, Network 8 is ready to offer VISION to any non-LDO clinic that has a PC with Windows 98 or higher, Microsoft Office 97 or 2000, and Internet capability.

CMS will provide the software delivered to you "ready to use." Network 8 will provide training.

What exactly does VISION do? The software enables you to enter your patient data into the computer (instead of filling out the Network forms) and send your information via the Internet to the Network. The Network retrieves the information from the Internet and automatically loads your patients' data into the CMS system-next day. No paper, no fax, no mail, no delay.

What's in it for you? Lots. HIPAA compliance, immediate access to your patient data, ability to print patient and facility reports, elimination of paper forms, more accurate data transmissions, and faster transmission of data for prompt beneficiary coverage. Additionally, CMS has signalled to us that they likely will mandate electronic submittal in the near future.

Interested? Look for a VISION Facility Interest and Readiness Survey that was sent to administrators of independent clinics recently. Network 8 will contact those whose readiness meets the CMS requirements.

Get with the program. Be a VISIONary.

FISTULA FIRST HIGH PERFORMERS RECOGNIZED

We would like to congratulate facilities that are meeting or exceeding the Fistula First project goal in prevalent patients. The following facilities have had an average AVF rate > 40% for the 1st or 2nd quarter of 2004. We encourage these facilities to continue their efforts and challenge others to join in the race!

Alabama

Atmore Dialysis Center
DCI Phenix City
FMC Bay Minette
FMC Chambers
FMC Dadeville
FMC Dauphin Island Parkway
FMC Eastern Shore
FMC Jackson (Tombigbee)
FMC Langdale
FMC Magnolia
FMC Monroeville (Whetstone)
FMC Odyssey
FMC Opelika
FMC Port City Dialysis

FMC Thomasville
FMC Tuskegee
FMC University of South Alabama
FMC West Mobile
Gambro Healthcare Birmingham Central
Gambro Healthcare Birmingham H. T.
Gambro Healthcare Eufaula
Gambro Healthcare Russellville
Landmark Dialysis
Roanoke Dialysis Clinic
South Baldwin Dialysis Center
VA Birmingham

Mississippi

Bay Springs Dialysis Unit
FMC Bay St. Louis S. Ms. Kid. Ctr.
FMC Jackson
Laurel Dialysis Center
RCG Columbus
RCG Greenwood
RCG Indianola
RCG Louisville
RCG Macon
RCG Starkville
Richton Dialysis Unit

Tennessee

Bradley Dialysis Clinic
Chattanooga Kidney Center

Collierville Kidney Clinic
DCI Hixon
FMC Athens
FMC Johnson City
FMC Kingsport
FMC Morristown
FMC Mountain City
FMC Eastern Tennessee
Gambro Healthcare Columbia
Morristown Dialysis Center
VA Memphis
VA Nashville Dialysis Unit

Many of these facilities had achieved the goal prior to the Fistula First project. We commend them for leading the way. When interviewed, nurse managers attributed success to dedicated nephrologists, skilled surgeons, patient and staff education, and designated vascular access coordinators. All of these factors are incorporated in the Fistula First Change Package.

We encourage all nephrologists and facility staff to begin implementing the outlined changes to achieve project goals and improve patient outcomes and to let us know how we can help you overcome obstacles.

FOCUS ON... ANEMIA MANAGEMENT

Last month, each Medical Director, Administrator and Nurse Manager received a facility-specific copy of the 2003 Clinical Performance Measures (CPMs) and Elab report. Using this report, facilities were classified in the areas of hemodialysis adequacy and anemia management. The anemia classification groups were:

- Benchmark: >90% patients with Hgb > 11.0
- Met goal: 70%-89% patients with Hgb > 11.0
- Failed to meet goal: < 69% patients with Hgb > 11.0

While the majority of clinics are meeting goal, we would like to help increase the number of benchmark facilities while decreasing the number of facilities that failed to meet goal. To that end, a brief tutorial on factors causing hyporesponse to Epopen follows.

1. Inadequate dosage.
 - Is dose less than 50-100 units/kg TIW?
 - Have doses been missed or held? If hospitalized, has current Epopen order been communicated to acute unit?
 - Are dose adjustments being made too frequently? Most experts agree on dose changes no more frequently than every 4-6 weeks.
2. Iron deficiency. This is the most common cause of hyporesponse. Iron stores

must be sufficient to support new red cell formation.

- Is ferritin < 100?
 - Is transferrin saturation < 20%?
3. Blood loss.
 - Is there known blood loss? Does access bleed excessively after needle removal? Do dialyzer and/or bloodlines clot frequently? Has patient undergone surgery?
 - Are occult blood cards positive?
 4. Infection/inflammation. Interferes with red cell production by: (1) releasing cytokines, which inhibit red cell precursors, and (2) impairing iron metabolism.
 - Is ferritin increased while transferrin saturation is decreased?
 - Is WBC count elevated?
 5. Secondary hyperparathyroidism. Interferes with red cell production by (1) directly inhibiting of red cell development, and (2) diminishing bone marrow space due to marrow fibrosis.
 - Is parathyroid hormone level elevated?
 6. Aluminum toxicity. Interferes with red cell production by (1) inhibiting enzymes necessary for red cell growth, (2) interfering with iron transport, and, (3) increasing fragility of red blood cells.
 - Is aluminum level elevated?
 7. Additional medical conditions
 - Malignancy: impairs development of red blood cells/ destruction of red blood cells by chemotherapeutic agents
 - AIDS: decreased production of red blood cells in bone marrow/ destruction of red cells by medications/ inad

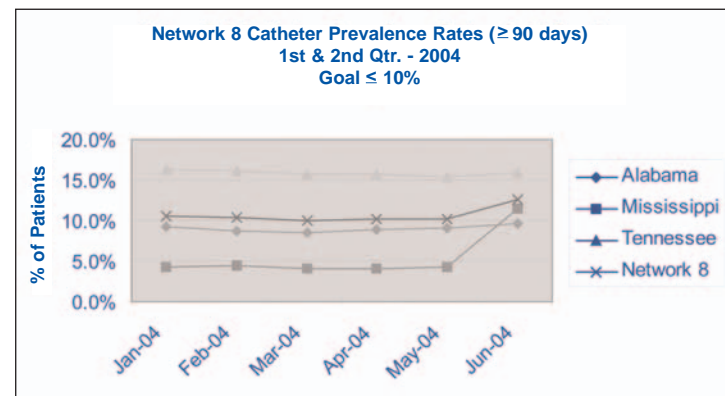
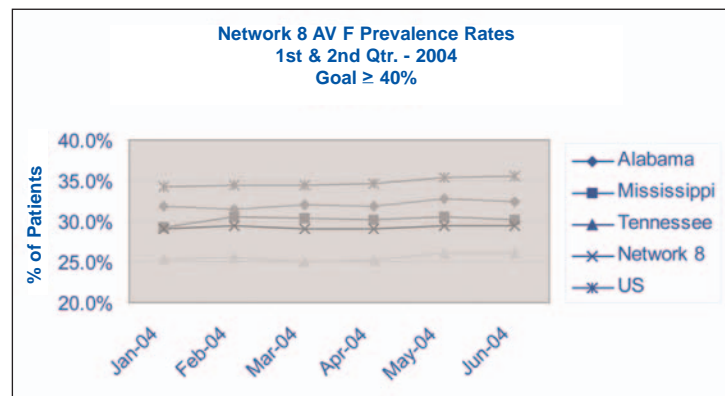
equate nutritional and vitamin stores for red cell production

8. Hemolysis. Exacerbates anemia by destroying mature red cells. Causes:
 - Medications.
 - Hypotonic and/or hyperthermic dialysate.
 - Waterborne toxin(s).
 - Chemicals such as bleach and formaldehyde.
 - Defective blood tubing.
 - Excessive negative pressure (arterial pressure more negative than -250 mm Hg).
9. Malnutrition. Thought to interfere with red cell production by (1) decreased protein levels lead brain to sense less need for oxygen and decrease hemoglobin production, and (2) decreased proteins available red cell formation
 - Is serum albumin low?
 - Is serum pre-albumin low?
10. Vitamin deficiency. Water-soluble vitamins are lost during dialysis. Folate and B complex vitamins are necessary for red cell production.
 - Is patient taking prescription B-complex vitamin?
 - Does patient take vitamin in morning before dialysis?

While not all-inclusive, we hope this review will help spotlight potential problem areas and lead to better anemia management outcomes.

If additional clinical assistance is needed, please contact Network 8. We will be glad to assist you with your anemia management efforts.

FISTULA FIRST DATA SNAPSHOTS



REIMBURSEMENT FOR VESSEL MAPPING

Evidence has shown that preoperative vessel mapping can lead to an increased number of suitable candidates for AVF placement and improved success rates of accesses once created. Therefore Fistula First has recommended that this procedure be included as part of the preoperative assessment.

Many practitioners have not widely utilized the procedure due to lack of reimbursement.

CMS recently published a proposal for new G-Codes to be used for venous mapping reimbursement. The renal and surgical communities were allowed to submit comments to CMS through September 24. The current proposal limited reimbursement to the operating surgeon only. Members of the Network 8 MRB and Fistula First Workgroup were encouraged to submit comments opposing this limitation, allowing for other practitioners to provide this service.

Network 8 will keep you posted on the progress of this proposal.

CMS INTRODUCES SCREEN TO INVESTIGATE EARLY INITIATION OF TREATMENT

CMS recently implemented a process to detect patterns in which patients are being placed on replacement therapy before it is medically necessary.

Under CMS protocol, Network organizations are using standardized software to identify facilities in which more than 10% of patients are being started with a serum creatinine so low that a modified MDRD (modification of diet in renal disease) calculation of GFR is over two standard deviations above the national average. Serum creatinine is the sole lab parameter used in the calculation.

A very high GFR usually indicates a level of residual renal function that would sustain a patient without dialysis therapy. Networks will contact physicians who started patients with a high GFR to verify that correct lab values were submitted on Form 2728. If higher serum creatinine values at the time of initiation are available, a new calculation will be made. If originally-submitted values were correct, the nephrologist will be asked to comment on the clinical circumstances of the patient at initiation.

Medical directors of affected facilities will be notified when their facilities exceed the threshold.