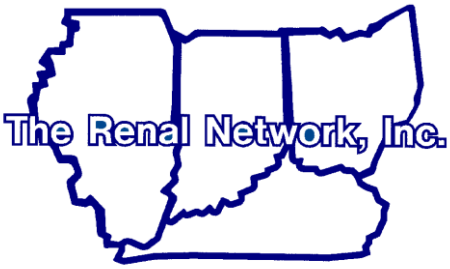

2004 ANNUAL REPORT

FOR

END-STAGE RENAL DISEASE NETWORK 9/10

THE RENAL NETWORK, INC.

Submitted By:
The Renal Network, Inc.
911 East 86th Street, Suite 202
Indianapolis, IN 46240
(317) 257-8265

Sponsored By:
Centers for Medicare & Medicaid Services
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Date: June 30, 2005

1. PREFACE

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June 30, 2005

I am proud to present the ***2004 Annual Report for End-Stage Renal Disease (ESRD) Network 9/10,*** which outlines a year of Network activities, and is made possible by the coordinated effort among health care providers, patients, and Network staff.

The Renal Network, Inc. (ESRD Network 9/10) is an independent agency that monitors the treatment of patients with ESRD in Illinois, Indiana, Kentucky, and Ohio. A total of 18 ESRD Networks throughout the country provide oversight of dialysis and transplant centers. The goal of the ESRD Networks is to assure appropriateness of dialytic care while fostering patient independence and well-being. ESRD Networks are funded through the Centers for Medicare and Medicaid Services (CMS).

The Renal Network, Inc., fosters and appreciates patient participation at all levels of its operation from the Board of Trustees, the Medical Review Board, the Pediatric Renal Group, the Patient Leadership Committee and Network Coordinating Council to each individual dialysis unit.

Our committee members are volunteers who have given of their time to improve the quality of care provided to patients receiving treatment for ESRD. Their contributions of time, effort, dedication and expertise have enabled our Network to go well beyond the requirements of our CMS contract to drive a progressive pro-active organization. We are especially grateful to for the contributions of the steering committee overseeing the Fistula First Initiative – the Vascular Access Advisory Panel. Under the leadership of Dr. Peter DeOreo as chair, their expertise has helped Network 9/10 improve in the area of fistula placement and maintenance. Increasing the use of fistulae is a national, as well as a Network, goal, one which will ensure better quality of care for all hemodialysis patients.

I wish to thank all the dedicated professionals, including those in each of our dialysis and transplant facilities and the Network administrative office, without whose hard work and perseverance the Network accomplishments would not have been possible. I am proud of my association with The Renal Network, Inc., and I expect that the contributions of our stakeholders will continue to make our Network a model for others to emulate.

Sincerely,

Jay B. Wish, M.D.
President

THE RENAL NETWORK, INC.
2004 ANNUAL REPORT

2. INTRODUCTION

A. Network Description

The Renal Network encompasses the states of Illinois, Indiana, Kentucky, and Ohio. Network 9 includes the states of Indiana, Kentucky and Ohio. Illinois is a single state Network, Network 10. The total population in the four-state area is 34,273,846 ("State Population Estimates: April 1, 2000 to July 1, 2002, U.S. Census Bureau Quick Facts, Illinois, Indiana, Kentucky and Ohio," U.S. Department of Commerce, Bureau of the Census).

Small increases in incidence and prevalence during 2004 for both Network 9 and Network 10 illustrate that the chronic dialysis population continues to grow. A one-year comparison of incidence and prevalence of all ESRD patients is shown below.

Incidence	2004	2003	Percentage Change
Network 9	8,011	7,743	3.4%
Network 10	4,482	4,416	1.5%
Prevalence	**2004**	**2003**	**Percentage Change**
Network 9	22,978	22,290	3%
Network 10	13,395	13,126	2.1%

The following data for race and ethnicity are taken from "2001 Population Estimates - U.S. Census Bureau Quick Facts, Illinois, Indiana, Kentucky and Ohio," U.S. Department of Commerce, Bureau of the Census."

Illinois, "The Prairie State," ranks 5th among all states in population at 12,600,620. Figures from the U.S. Department of Commerce, Bureau of the Census, show the population divided by race as:

White	73.5%	Black	15.1%
Other	11.4%		

About 12% of the population is defined as Hispanic in ethnicity. Divided by age groups, approximately 26% of the population was under the age of 18; 61% were between the ages of 18 and 64; and 12% were aged 65 or greater. Currently, the female population is approximately 51% and the male population is 49%.

One-half of the population of the state lives in the metropolitan Chicago area. In total, 83 percent of the population live in urban areas and 17 percent of the population live in rural areas. Other urban areas in Illinois (with a population of greater than 100,000) are Springfield (the state capital), Rockford, and Peoria.

Indiana, "The Hoosier State," ranks 14th among all states in population at 6,159,068. Figures from the U.S. Department of Commerce, Bureau of the Census show the population divided by race as:

White	87.5%	Black	8.4%
Other	4.1%		

About 3.5% of the population is defined as Hispanic in ethnicity. Divided by age groups, approximately 26% of the population was at age 18 or under; 62% were between the ages of 18 and 65; and 12% were over the age of 65. Currently, the female population is approximately 51% and the male population is 49%.

About two-thirds of Indiana's population live in urban areas. Indianapolis, the state capital, is the largest city in the Network area, as well as Indiana, with a population of over 1,000,000. Other urban areas in Indiana (with population greater than 100,000) are Fort Wayne, Gary, Evansville and South Bend.

Kentucky, "The Bluegrass State," ranks 25th among all states in population at 4,092,891. Figures from the U.S. Department of Commerce, Bureau of the Census show the population divided by race as:

White	90.1%	Black	7.3%
Other	2.6%		

About 1.5% of the population is defined as Hispanic in ethnicity. Divided by age groups, approximately 25% of the population was at age 18 or under; 62% were between the ages of 18 and 65; and 13% were over the age of 65. The female population is approximately 52% and the male population is 48%.

The Kentucky population is about evenly divided between rural and urban dwellers. Urban centers (with population greater than 100,000) are Louisville, Lexington, Owensboro, Covington, Bowling Green, Paducah, Hopkinsville, and Ashland. Kentucky's state capital is Frankfort.

Ohio, "The Buckeye State," ranks 7th among all states in population at 11,421,267. Figures from the U.S. Department of Commerce, Bureau of the Census show the population divided by race as:

White	85%	Black	11.5%
Other	3.5%		

About 1.9% of the population is defined as Hispanic in ethnicity. Divided by age groups, approximately 25% of the population was at age 18 or under; 61% were between the ages of 18 and 65; and 14% were over the age of 65. Currently, the female population is approximately 52% of total population and the male population is 48%.

About three-quarters of the population of Ohio live in urban areas. Urban centers (with population greater than 100,000) include Cleveland, Columbus (the state capital), Cincinnati, Toledo, Akron, Dayton, and Youngstown.

B. Network Structure

1. Staffing

The Renal Network employs 18 full-time employees:

Susan A. Stark, Executive Director: Project Director, responsible for the overall operation of all functions of The Renal Network, Inc.

Bridget M. Carson, Assistant Director: provides back-up in administrative responsibilities. This position is also responsible for coordinating activities for Medical Review Board, the Pediatric Renal Group, the Nominating Committee and the annual Nephrology Conference.

Janet Nagle, Office Manager: responsible for operation of the Network office, including bookkeeping and personnel.

Raynel Kinney, R.N., C.N.N., C.P.H.Q., Quality Improvement Director: oversees all quality improvement projects and intervention activities, and coordinates the clinical performance measures project.

Mary Ann Webb, M.S.N., R.N., C.N.N., Quality Improvement Coordinator: assists with quality improvement and intervention activities and grievance resolution.

Patricia Coryell-Hendricks, R.N., C.N.N., Quality Improvement Coordinator: assists with quality improvement and intervention activities.

Janie Hamner, Quality Improvement Assistant: responsible for support to Quality Improvement Department.

Dolores Perez, M.S., Communications Director: oversees the Network Web sites, publications and resource information; assists with implementation of all patient activities.

Kathi Niccum, Ed.D., Patient Services Director: responsible for direction of all patient activities including grievance resolution.

Leanne Emery, M.A., Patient Services Assistant: provides secretarial support to the Patient Services Department.

Richard Coffin, Data Services Director: responsible for all programming needs and also directs the staff of the Data Services Department.

Christina Harper, Data Manager: oversees the day-to-day operation of the Data Services Department.

Marietta Gurnell, Information Management Coordinator: responsible for administering data clean-up tools and CMS notifications on the SIMS database to correct errors in the system.

Cynthia Lacey, Data Specialist: Responsible for tracking patients for Network 10 facilities.

Deborah Laker, Data Specialist: responsible for tracking patients for Network 9 facilities.

Katy Simmons, Data Specialist: Responsible for tracking patients in Network 9 facilities.

Helen McFarland, Special Projects Coordinator: Responsible for validation activities for the Network 9/10 database.

Rita Cameron, Secretary: responsible for reception and secretarial support.

2. Committees

Network Coordinating Council: The Network Coordinating Council (NCC) is composed of representatives of ESRD providers in Illinois, Indiana, Kentucky, and Ohio which are certified by the Secretary of Health and Human Services to furnish at least one specific ESRD service. The NCC includes a representative of each of the current Medicare approved ESRD facilities. Each facility has a single representative, designated by its chief executive officer or medical director, who is approved by the governing board of the facility. The NCC is responsible for the election of members to the Board of Trustees and the Medical Review Board. Elections are held by mail-in ballot. The Council meets once annually. During 2004, the Council met on June 10.

During 2004, the following occurred:

- The 2004 Nephrology Conference was held at the Sheraton Chicago Hotel and Towers in downtown Chicago on June 10 and 11. The Conference offered educational programs for administrators, physicians, nurses, social workers, dietitians, and technicians. A BONENT certification examination was held for nurses and technicians on June 9. During the Conference, the annual meeting of the NCC was held on Thursday, June 10. At this time the Council was updated on activities with Network 9/10 as well as those activities related to the Centers for Medicare and Medicaid Services (CMS) and The Forum of ESRD Networks. Dialysis facilities within Network 9/10 were informed of the outcomes of the CMS Clinical Performance Measures Project and the Fistula First: National Vascular Access Improvement Initiative. The nominating process for open positions to the MRB and the BOT ended at the conclusion on the NCC meeting.

- The 2004 slates for membership on the Board of Trustees and Medical Review Board were mailed in September for the 2004 election after the nominating process was completed. (Nominations were accepted from January through June 10 for open positions.) Members were elected to both committees by mail-in ballot in the fall. Terms of office were to begin on January 1, 2005 and end on December 31, 2007.

- 2003 data were presented and the 2003 Annual Report was distributed to facility representatives and posted to the Network Web site (www.therenalnetwork.org).

Board of Trustees: The Board of Trustees is the chief governing body of ESRD Network 9/10. The Board of Trustees holds the Network contracts for ESRD Network 9/10 with the CMS, and is responsible for meeting contract deliverables and oversight of the administration of the Network budget.

In 2004, the Board of Trustees was composed of 21 members and an ex-officio immediate Past President, elected for three year terms of office including:

Six Renal Physicians
Two At-Large Physicians
Four ESRD Patients (three positions filled/one vacancy)
One Non-Categorical Position
Chairperson of the Medical Review Board
One Nurse
One Social Worker
One Administrator
One Dietitian
One Technician
One Legal Representative
One Financial Representative
The Past President

The Board of Trustees met on January 7 and October 6. A conference call was held for the BOT on July 21.

Members of the Board of Trustees for 2004 were:

Jay B. Wish, M.D., President
Chester Amedia, Jr., M.D., Treasurer
George Aronoff, M.D., MRB Chair
William (Dirk) Combs
Evernard Davis
Billie Goble, M.S.W.
Richard J. Hamburger, M.D.
Mark Parks, C.H.T.
Janeen Beck Leon, R.D.
Stanton Schultz, M.D.
Cheryl Sweeney, R.N., C.N.N.
Craig Stafford, M.D., Vice President
Pat Gunnerson, Secretary
Emil P. Paganini, M.D., Past President
Dan DeFalco, CPA
Leslie DeBaun, R.N.
Thomas Golubski, M.D.
Stephen Korbet, M.D.
Benjamin Pflederer, M.D.
Jane Robinson, M.S.N., R.N.
Joseph Scodro, Esq.

During 2004, the Board of Trustees accomplished the following:

- Network financial records were reviewed and expenditure reports approved.
- The Board of Trustees monitored and approved the activities of the Medical Review Board, the Pediatric Renal Group, the Patient Advisory Councils, the Nominating Committee, the Strategic

Planning Committee, and the Nephrology Conference Program Committee. Committee progress reports included updates on projects and action items.

- The Board of Trustees was updated on activities with CMS, The Forum of ESRD Networks, and contract issues. In 2003, the Board empowered the Nominating & Bylaws committees to work together to suggest changes in the membership of the Board and the MRB in accordance with CMS contract mandates. A bylaws change was approved to accomplish a downsizing in numbers of positions for both the Board of Trustees and the Medical Review Board. The downsizing was accomplished during the 2004 election.

- The Board approved the slates for election to the MRB and the BOT. The slates were formulated from nominations from the Network at large. The Nominating Committee reviewed the nominations to ensure the candidates were qualified for the positions being sought. The slates were sent on the BOT for approval, then mailed to the NCC facility representatives for voting. The election was final and results were announced by year-end.

- Oversaw the development of Network projects by special contract with CMS, including the development of a pilot for nursing home dialysis and the Overcoming Barriers to Transplant project.

Medical Review Board: The Medical Review Board (MRB) is composed of 28 members, elected for three year terms of office including:

10 Renal Physicians	2 ESRD Nurses
2 Physicians At Large	1 Transplant Physician
1 Pediatric Renal Physician	2 ESRD Social Workers
2 ESRD Dietitians	2 ESRD Facility Administrators
4 ESRD Patients	2 ESRD Technicians

The Medical Review Board functions with the concurrence and subject to the review and control of the Board of Trustees. The President of the Board of Trustees serves in an ad hoc capacity. The MRB performs functions prescribed by the regulations issued by the Secretary of Health and Human Services, as well as other duties related to quality improvement, vocational rehabilitation, and patient concerns as requested by the Network Coordinating Council. The MRB met on March 9 and 10, August 24 and 25, and November 16 and 17.

Members of the MRB for 2004 were:

George Aronoff, M.D., Chairperson	Ashwini Sehgal, M.D., Vice Chairperson
Steve Adley, B.S.N.	Rajiv Agarwal, M.D.
Dianne Carter	Deepa Chand, M.D.
David Charney, M.D.	Paul Crawford, M.D.
Catherine Colombo, RN	Peter DeOreo, M.D.
John Ducker, M.D.	Lorraine Edmond
Andrew Finnegan, C.H.T.	Sandra Fritzsch, R.N., J.D.

Elisabeth Fry, R.D., L.D.
Carol Jackson, M.S.W.
Stephen McMurray, M.D.
Romeo Micat, M.D.
Dennis Muter, C.H.T.
Bonnie Orlins, M.S.S.A.
Rosemary Ouseph, M.D.
Marcia Silver, M.D.
Charles Sweeney, M.D.
Linda Ulerich, R.D.
Elaine Worcester, M.D.

Clifford Glynn, C.H.T.
Kathy Lord, M.S.W.
Jennifer Messer, C.H.T.
Jackie Miller, B.S.N.
Kathy Olson, R.N.
Julie Prinsen, R.D.
C. Frederic Strife, M.D.
Martinlow Spaulding
Eddie Taylor
Jay B. Wish, M.D.
Steven Zelman, M.D.

During 2004, the Medical Review Board:

- Continued the implementation of the CMS Fistula First: National Vascular Access Improvement Initiative. A special Vascular Access Advisory Panel (VAAP) continued to assist the MRB coordinate this project. The Network 9/10 Fistula First initiative included comprehensive and discipline specific Learning Sessions, dissemination of educational resources to dialysis facilities, placement of resources and educational materials on the Network Web site, and technical assistance to regional vascular access committees.

- Reviewed and updated the CPM Plan. Outcomes were reviewed, as data was available. QI activities/interventions were developed as necessary.

- Oversaw the distribution of the Facility Clinical Performance Measures Reports that included the Needs Assessment Reports for hemodialysis adequacy and anemia management. The Needs Assessment Reports show facility data compared to the top 20-percentile facility rates for adequacy and anemia management care processes. The facility reports detailed the fourth quarter 2003 data collection outcomes and were distributed to facility medical directors, administrators, and nurse managers. The facility reports were mailed to approximately 450 dialysis programs and 600 nephrologists during July 2004. The facility feedback reports will continue with the 2004
  4th quarter lab data collection with CMS approval.

- Oversaw the dissemination of a Facility Profile, which displays descriptive data from each facility, with comparisons of regional, state, Network and national statistics for those same areas, including demographic and diagnosis data. Included also are SMR and gross mortality. These profiles are distributed annually to each facility to help them in their continuous quality improvement efforts.

- Oversaw the activities of the Pediatric Renal Group, a subcommittee of the Medical Review Board. The goal of the Group is to act as a resource to the Network on the care and treatment of pediatric dialysis and transplant patients. The Pediatric Renal Group met on March 14, June 10 and September 30 and October 1. Subcommittee work was accomplished through conference calls during the year.

- Received continuous updates on the activities of CMS and the ESRD Network Scope of Work, the United States Renal Data System (USRDS), The Forum of ESRD Networks, and the Quality Assurance Committee of The Forum.

- Reviewed data profiles, including rates for clinical performance measures, mortality, home therapy, and transplantation.

- Reviewed grievances filed with the Network.

- Oversaw the implementation of the national CMS clinical performance measures project.

- Formulated a response to the CMS request for re-evaluation of Epotein reimbursement.

- Oversaw the plan for MRB review of 2728 forms for GFR. The SIMS database was queried in September 2004 to identify dialysis facilities and physicians with greater than 10% incident patients during 2003 initiating dialysis with a GFR greater than 25.87ml/min/1.73m² in adults and 33.35ml/min/1.73m² in children. The result of the query showed 118 patients from 68 facilities identified, under the care of 62 different nephrologists. Documentation was requested from the physicians justifying the initiation of dialysis in these patients. Continued to review GFR rates and follow-up with outliers.

- Oversaw all quality improvement and education projects that were in the process of development.

- Developed project ideas for concept papers to submit to CMS.

Transplantation Task Force. This committee was discontinued during 2004. Transplantation activities were conduced under the Medical Review Board and also through the Dialysis Facility-Specific Kidney Transplant Referral Measures Project which was coordinated for CMS by ESRD Network 9/10.

Academic Consortium: The Consortium was maintained as a resource and information dissemination network. Through members of the academic community, the Network was able to co-sponsor the Chicago Nephrology Day on June 11, as a component of the 2004 Nephrology Conference. The day was open to physicians and physicians-in-training from throughout the four-state area. By year-end, plans were under way for the Network to co-sponsor the Midwest Nephrology Fellows Research Day with the Indiana University School of Medicine. This event was set for May 24, 2005 to take place as a component of the 2005 Nephrology Conference.

Patient Leadership Committee: The purpose of the Patient Leadership Committee (PLC) is to identify and address ESRD patient needs and concerns through the development of educational projects and activities. The PLC met on March 19, July 16, and November 12, 2004.

Members of the Patient Leadership Committee during 2004:

Tracee Bauer	Katrina Boehmer
Celia Chretien	William Combs
Helen Considine	Leslie DeBaun
Loraine Edmond	Donna Felton
Craig Fisher	Barbara Gronefeld
Sonia Juhasz	Kathy Kirk-Franklin
Evaret Lesser	Ellen Newman
John O'Meara	Dewey Piper
Mary Ramsey	Janet Schueller
David Schowoegler	Fonda Setters
Martinlow Spaulding	Julie Thompson
Guy Tibbels	Lynn Winslow

During 2004, the PLC accomplished the following:

The **Pediatric Subcommittee** updated the information for an educational project entitled *Your Kidneys and You*. It is geared toward school age children to educate them about the kidney disease of their loved ones and to help them cope with chronic illness in their family.

The **Family Subcommittee** developed articles for the *Renal Outreach* on issues related to families and having a family member with kidney failure. The committee also developed a multimedia project with IUPUI New Media Program for families, an animated video on the impact of kidney disease on the family, entitled *The Uninvited Guest*.

The **Special Projects Subcommittee** developed a monthly calendar for dialysis facilities titled *Conflict Management, A Leadership Perspective to Growth Through Problem Solving*. The committee also developed a brochure entitled *Ease the Ouch* that was directed to patients to take the fear out of AV fistula placement and articles that addressed vascular access for the patient newsletter.

The **Vocational Rehabilitation Subcommittee** gathered input from state vocational offices about their views of ESRD patients and how to work together. It also addressed the issue of monitoring patients who receive vocational rehabilitation.

3. CMS NATIONAL GOALS & NETWORK ACTIVITIES

All ESRD Network organizations are responsible for the goals listed in the following section. Under each goal are the activities accomplished during 2004 toward meeting each goal:

GOAL 1: Improving the quality of care of health care services and quality of life for ESRD beneficiaries, including assistance in resolving patient complaints and grievances.

Improving quality of care for ESRD beneficiaries was accomplished through clinical initiatives developed and supervised by the Medical Review Board and implemented by the Quality Improvement Department of The Renal Network, Inc. These activities can be categorized in five main subject areas; each is described in the following section of this report:

A. The Clinical Performance Measures Project
B. Network 9/10 CPM Interventions
C. CMS National CPM Project
D. Network Special Projects/Studies
E. Focused Quality Assurance Activities
F. Grievance Activities

A. The Clinical Performance Measures Project

The Clinical Performance Measures (CPM) Project contributes to a consistent clinical database to assess patient outcomes and support improvement activities at Network 9/10 and facilities. The elements of the database represent clinical measures indicating key components of ESRD patient care. In 4th quarter 2003 (October, November and December) approximately 80% of hemodialysis facilities and in the October 2003–March 2004 PD cycle approximately 60% of peritoneal dialysis facilities voluntarily participated in the CPM data collection for Network 9/10.

The goals of the project were to:

(1) increase the knowledge and awareness of the CPM Project to Network 9/10 ESRD providers,
(2) analyze the applicability of the CPMs on facility and Network levels,
(3) implement improvement intervention programs on a Network-wide level, and,
(4) improve patient outcomes.

The Renal Network maintains a process to collect, analyze, and provide data feedback reports to facilities. In the 4th quarter HD and October 2003-March 2004 PD CPM data collection, facilities were asked to voluntarily submit data via collection form. The data were analyzed by the MRB and feedback reports were distributed in July 2004 detailing the data collection outcomes. The reports compared same type dialysis environments to their counterparts in the network region, i.e. Large Dialysis Organization (LDO), Hospital, and Independent. The feedback reports also included Needs Assessment Reports for hemodialysis adequacy and anemia management. The Needs Assessment

Reports show facility data compared to the top 20-percentile facility rates for adequacy and anemia management care processes. The Network also reported incident patient information using the data that was available. Aggregate information was placed on the Network 9/10 Web site. The facility feedback reports will continue with the 2004 4th quarter CPM data collection, pending CMS approval.

B. Network 9/10 CPM Interventions.

The goals of the CPM interventions are to:

(1) increase the knowledge of the CPM project to Network 9/10 ESRD providers,
(2) standardize the data collection process
(3) analyze the applicability of the CPM on the facility and network levels, and,
(4) implement programs and projects that can be repeated on a facility and Network-wide level.

Interventions included facility and physician data collection, feedback reports, and regional education workshops. The focus was on K/DOQI™ guidelines, physician-patient outcome data, and facility plans for improvement. Feedback reports were specifically targeted to physicians, medical directors, administrators and nurse managers. In addition to the physician reports, 18 physician practice reports were requested and distributed. Multi-color reports displayed data in tables and charts.

In July 2004, hemodialysis adequacy and anemia management Needs Assessment Reports were distributed as a part of the facility feedback reports detailing the fourth quarter 2003 data outcomes.

Areas for comparison were:

(1) percentage of patients with URR $\geq$ 65%
(2) average treatment time
(3) frequency table of treatment time distribution
(4) average blood flow at one hour
(5) frequency table of blood flow distribution
(6) percentage patients with catheter.

In November 2004, Quality Improvement Resources were mailed to the administrators of 37 facilities. The facilities were targeted because their outcomes were two standard deviations below the mean during the fourth quarter of 2003. Areas targeted were hemodialysis and peritoneal dialysis adequacy, anemia management and hemodialysis vascular access. Binders of quality improvement tools were individualized for each facility according to need. The tools were also available on the Network Web site.

In 2004, Network 9/10 Clinical Performance Goals for adequacy of dialysis, anemia management, and vascular access were available on the Network 9/10 Web site, www.therenalnetwork.org.

Adequacy of Dialysis Goals 2003-2004 – Hemodialysis

All patients measured for adequacy every month.
≥ 95% of patient population achieve URR ≥65%
≥ 95% of patient population achieve Kt/V $_{\text{Daugirdas II}}$ ≥1.2

Adequacy of Dialysis Goals 2003-2004 - Peritoneal Dialysis

All patients measured for adequacy every four months.
CAPD ≥ 85% of patient population achieve weekly creatinine clearance ≥ 60 L/bsa or weekly Kt/V ≥2.0
CCPD ≥ 85% of patient population achieve weekly creatinine clearance ≥ 63 L/bsa or weekly Kt/V ≥2.1

Anemia Management Goals 2003-2004 - Hemodialysis & Peritoneal Dialysis

All patients measured every month of PD clinic visit.
≥ 85% of patient population achieve hemoglobin ≥11 gm/dL

Hemodialysis Vascular Access Goals 2003-2004

≥ 40% prevalent patient population fistula rate $^{\text{DOQI}^{TM}}$
≤ 10% prevalent patient population catheter rate $^{\text{DOQI}^{TM}}$

C. CMS National CPM Project.

All 18 Networks participated in the national Clinical Performance Measures (CPM) project. Random samples of hemodialysis and peritoneal dialysis patients were drawn. The hemodialysis sample had sufficient size to be representative of each Network. The peritoneal dialysis sample size was used for national rates only.

Chart C.1 shows the national comparison of Network 9 and Network 10 rankings for clinical outcomes to the other 16 networks for the past four years.

Chart C.1. Network 9/10 National Ranking for 4Q00-4Q03
Data for Adult (≥18 years) In-center Hemodialysis Patients
Source: Annual Report, ESRD Clinical Performance Measures Project, CMS, December 2001, 2002, 2003 & 2004.

Clinical Characteristic	Network 9				Network 10			
	4Q00	4Q01	4Q02	**4Q03**	4Q00	4Q01	4Q02	**4Q03**
Percentage Patients with Average:								
URR ≥ 65%	10	5	12	7	15	13	5	6
Kt/V ≥ 1.2	8	5	8	6	11	10	12	10
Percentage Prevalent Patients:								
AV Fistula	10	13	12	13	13	8	10	7
Catheter (low rate)	16	17	18	17	8	9	12	15
Albumin ≥3.5 gm/dL	17	10	17	15	1	3	2	6
Albumin ≥4.0 gm/dL	16	16	15	6	1	7	1	1
Hgb ≥ 11gm/dL	12	16	14	9	1	8	1	1
Ferritin ≥100 ng/mL	4	1	1	8	1	3	3	4
TSAT ≥ 20%	15	14	14	17	2	7	8	5
% patients receiving EPO with:								
HGB value 11-12 gm/dL	10	18	16	17	12	16	18	11
% patients prescribed IV Iron	1	1	1	2	3	3	8	10
% patients prescribed EPO Subc	1	1	7	4	4	7	4	10

Chart C.2 shows the Network 9 and Network 10 random samples for the CMS National CPM Project. Data reliability of the national sample was conducted on five percent of the random sample. Network 9/10 staff abstracted patient charts for this process.

Chart C.2. National Clinical Performance Measures Project Network Random Samples, 4Q03 – HD & Oct03-Mar04 – PD (Adult ≥ 18 years)

Pt. Characteristic	Net 9 HD		Net 10 HD		U.S. HD*		Net 9 PD		Net 10 PD		U.S. PD*	
	#	%	#	%	#	%	#	%	#	%	#	%
Total	497	100	491	100	8634	100	122	100	61	100	1377	100
Male	273	55	269	55	4601	53	63	52	37	61	709	51
Female	224	45	222	45	4033	47	59	48	24	39	668	49
Race												
AI/AN	1	.2	0	0	164	2	1	.8	0	0	15	1
AS/PI	2	.4	18	4	363	4	0	0	3	5	80	6
Black	172	35	209	43	3086	36	27	22	20	33	353	26
White	312	63	250	51	4769	55	92	75	34	56	880	64
Oth/Unk	10	2	14	3	252	3	2	2	4	7	49	4
Ethnicity												
Hispanic	10	2	31	6	1120	13	0	0	6	10	173	13
Non-Hispanic	447	90	379	77	7359	85	111	91	50	82	1189	86
Oth/Unk	39	8	81	17	155	2	11	9	5	8	15	1
Age												
18 – 49	113	23	123	25	2031	24	38	31	26	43	501	36
50 – 59	85	17	110	22	1739	20	28	23	13	21	330	24
60 – 64	52	11	44	9	944	11	9	7	5	8	142	10
65 – 69	67	14	45	9	1031	12	19	16	5	8	143	10
70 – 79	121	24	109	22	1908	22	20	16	10	16	206	15
80+	59	12	60	12	981	11	8	7	2	3	55	4
Primary Diag.												
DM	216	44	169	34	3650	42	39	32	18	30	489	36
HTN	123	25	176	36	2413	28	33	27	21	34	329	24
GN	54	11	60	12	834	10	22	18	10	16	206	15
Other/Unk	104	21	86	18	1737	20	28	23	12	20	353	26
Duration - years												
< 0.5	71	14	64	13	1082	13	22	18	8	13	181	13
0.5 – 0.9	59	12	51	10	1070	12	18	15	12	20	208	15
1.0– 1.9	93	19	95	19	1688	20	29	24	10	16	335	24
2.0+	274	55	281	57	4772	56	52	43	31	51	649	48

*CMS 2004 Annual Report, ESRD Clinical Performance Measures Project, December 2004.
May not add up to 100% or totals due to rounding or missing data elements.

D. Network special Projects/Studies

1. Quality Improvement Projects–The Fistula First Initiative. The development of Quality Improvement Projects (QIP) is mandated in the Network 9/10 contract with CMS. The QIPs are developed and directed by the Medical Review Board (MRB). In 2004, the majority of quality improvement efforts were focused on the Fistula First Initiative.

Background: In 2003 the ESRD Networks and CMS, along with clinicians, dialysis providers, and patients, developed a three-year plan called the National Vascular Access Improvement Initiative (NVAII). This initiative has since been renamed Fistula First. This plan implements strategies for the improvement of patient vascular access outcomes to reach the CPM and K/DOQI guidelines for AVF use of 50% incidence and 40% prevalence.

Fistula First aims to build on prior work and to take advantage of system-level diagnosis and strategies for improvement. Collaboration between Networks, providers, physicians, vascular surgeons, and health professionals is key to spread the change ideas for improving AV fistulas.

Primary objectives:

- To increase prevalence rate of AVF in Network 9 from 30.3 percent in 2002 to 34.3 percent in 2006 (an increase of 4%) and increase Network 10 from 33.3 percent in 2002 to 37.3 percent in 2006 (an increase of 4%).
- To increase the incidence rate of new ESRD patient AVF, i.e. increase 5% per year.
- Educate providers, physicians, and vascular access surgeons on documentation of AVF assessment pre hemodialysis access placement
- Educate providers, physicians, and vascular access surgeons on the AVF improvement strategy

Methods:

- Establish a Vascular Access Advisory Panel (VAAP) to oversee the project and report to the MRB.
- Conduct regional Learning Sessions.
- Conduct monthly Awareness/Educational Campaigns.
- Maintain vascular access feedback reports to facility vascular access personnel and physicians.
- Establish and maintain communication with facility vascular access personnel and physicians.

Actions:

a. Key individuals were invited to participate on Vascular Access Advisory Panel (VAAP); members of the panel include:

Peter DeOreo, M.D., Chair, Centers for Dialysis Care, Cleveland, Ohio
Anil Agarwal, M.D., Ohio State University, Columbus, Ohio
George Aronoff, M.D., University of Louisville, Louisville, Kentucky
Michael Brier, Ph.D., University of Louisville, Louisville, Kentucky
Luis Cespedes, M.D., RCG-Villa Park, Elmhurst, Illinois
Wendy Jagusch, R.N., Centers for Dialysis Care, Cleveland, Ohio
Stephen Jensik, M.D., Rush Presbyterian, Chicago, Illinois
Richard Keen, M.D., Rush University, Chicago, Illinois
Linda Luevana, R.N., Rush Presbyterian, Chicago, Illinois
Gordon McLennan, M.D., Indiana University Medical Center, Indianapolis, Indiana
Jackie Miller, R.N., Renal Care Group, Fort Wayne, Indiana

Rino Munda, M.D., University of Cincinnati, Cincinnati, Ohio
Tim Pflederer, M.D., Renal Care Associates, Peoria, Illinois
Prabir Roy-Chaudhury, M.D., University of Cincinnati, Cincinnati, Ohio
Mary Showers, R.N., VA Medical Center, Cleveland, Ohio
Greg Stephens, M.D., The Christ Hospital, Cincinnati, Ohio
Jay B. Wish, M.D., University Hospitals of Cleveland, Cleveland, Ohio

b. Maintain and improve communication with vascular access stakeholders:
Stakeholders were identified as the facility medical director, administrator, vascular access coordinators, and nephrologists, as well as patients, vascular access surgeons, and interventional radiologists. This would include, and not be limited to, constructing a database of vascular access surgeons and coordinators.

c. Identify Health Service Areas (HSAs) and facilities for levels of participation:
Areas of Networks 9/10 that demonstrated a need for improvement were targeted to participate in regional Learning Sessions. Physicans, vascular surgeons, interventional radiologists, interventional nephrologists and nurses were invited to these regional meetings that provided information and tools based on change kit concepts. Utilizing demographic data from the Network 9/10 Health Service Area regions and vascular access data five areas were identified that represent 46% of the network patient population.
Facilities that had 30% fistulas and 30% catheters as of the fourth quarter 2002 CPM data (120 facilities) were encouraged to participate in the Learning Sessions.

d. Develop the project timeline.

e. Prepare the Internet communication: Activities included updating the Network 9/10 Web sites, populating the email service and conducing Web-Ex conferences for communicating educational items and information to various target and participating groups, i.e. VAAP, corporate professionals, and vascular surgeon and/or nephrologists.

f. Maintain monthly educational communications with key individuals throughout the Network area.

Learning session findings: Beginning in 2003, Network 9/10 sponsored regional Learning Sessions designed to complement the coordination of group practices, including multi-dimensional teams. These Learning Sessions targeted specific facility and physician care processes that will improve vascular access outcomes. The speakers were from the Nephrology, Vascular Surgery, and Interventional Radiology services. These physicians presented innovative ideas and demonstrated practices that promoted team-building processes to improve the AV fistula rate.

Chart D.1 displays the statistics surrounding the Learning Sessions that were held beginning in 2003.

Chart D.1 2003-2004Learning Session Demographics

Learning Session	Target HSAs	Total Attend	Neph Attend	IR Attend	Surgeon Attend	Other Attend	% 30/30 Club Representation (120 Total)	% HSAs Represented (26 Total)	Returned Evaluations	% Returned Evaluations	% Positive Evaluations
Cincinnati Oct. 28, '03	A,B,C, D,O	58	20	0	11	27	7.5%	42%	46	79.3%	95%
Chicago Nov. 5, '03	M,U,P,, V,W,X	76	30	10	13	23	7.5%	39%	50	65.7%	93%
Indianapolis Jan. 28, '04	A,C,D, E,M,N, O,S,T	65	13	8	11	33	8.3%	39%	32	49.2%	90%
Columbus Mar. 9, '04	C,D,E, F,G,H, I,J,K,L	88	19	2	16	51	12.5%	42%	63	71.5%	91%
Springfield Apr. 21, '04	P,Q,R, S,T,U, V,W,X, Y,Z	29	6	1	4	18	1.6%	23%	27	93%	91%
Totals		316	88	21	55	152	34%	37% average (85% total)	191	66.5%	92% average

Year two of the Learning Sessions began in November 2004 and will continue into 2005. The Learning Sessions for year two were designed to take on a more comprehensive and discipline specific format. The session for nurses and facility staff focuses on developing a "Master Cannulator" program in the dialysis facility. The cannulation session is interactive and designed to assist facilities in finding solutions to barriers. The physician session presents innovative ideas in vascular surgery and highlights regional best practices that promote processes that demonstrate improvements in a facility or a group AV fistula rate.

Chart D.2 displays the statistics surrounding the first Learning Session for year two that was held in Chicago, Illinois in 2004.

Chart D.2 2004 Learning Session Demographics

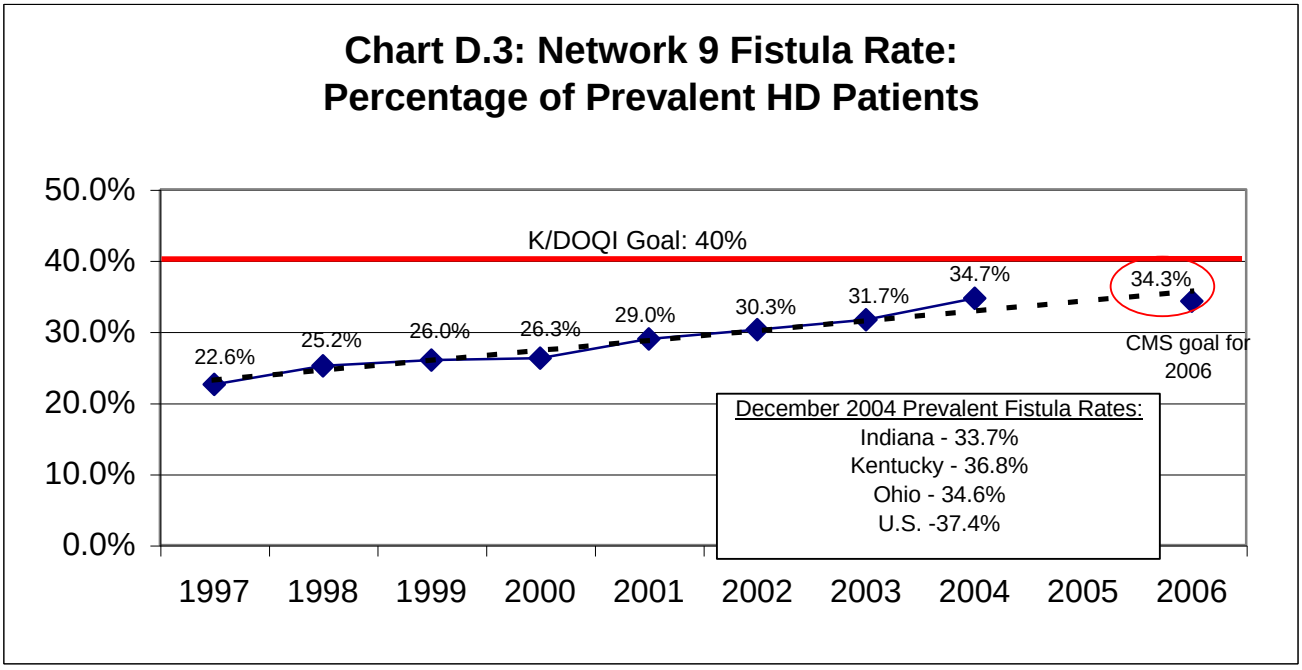
Learning Session	Target HSAs	Total Attend After-noon	Total Attend. Evening	Neph PM	Nurse/ Staff Attend PM	Vasc Surg PM	IR PM	HSAs Rep. Phys.	HSAs Rep. Nurse/ staff	Afternoon Staff-Pos Eval	PM Staff-Pos Eval	Phys - Pos Eval	CME Eval Ed. Obj.
Chicago, IL Nov 16, 2004	M,N,O, P,Q,R,S, T,U,V,W , X,Y,Z	59 Nurse/ staff	39 Nurse/ staff 19 Physicians	15	39	4	0	4 M,U, V,X	8 A,M,N S,U,V, Y,X	79%	76%	85%	82%

The remaining year two Learning Sessions will be held in Indianapolis, Indiana on January 19, 2005, Cincinnati, Ohio on February 3, 2005 and Columbus, Ohio on March 22, 2005.

The Learning Sessions have fostered interest in the regional areas where they were held and have led to the development of Vascular Access (VA) Leadership Groups. Cincinnati was the first Learning Session and is the most advanced with local meetings held to discuss commonalities and data collection. Network 9/10 is assisting at present to develop facility, nephrologist, and surgeon specific reports for the Cincinnati area.

Indianapolis was the second regional area that has developed a leadership group that has been active in developing policies and procedures for use by dialysis facilities, hospital acute units, surgeons, and case managers. The Indianapolis area is also in the process of designing an education program focusing on cannulating fistulas and using the buttonhole technique.

Review of the data: Chart D.3-D.5 displays the percentage of prevalent and incident HD patients with fistulas in Network 9 and Network 10.



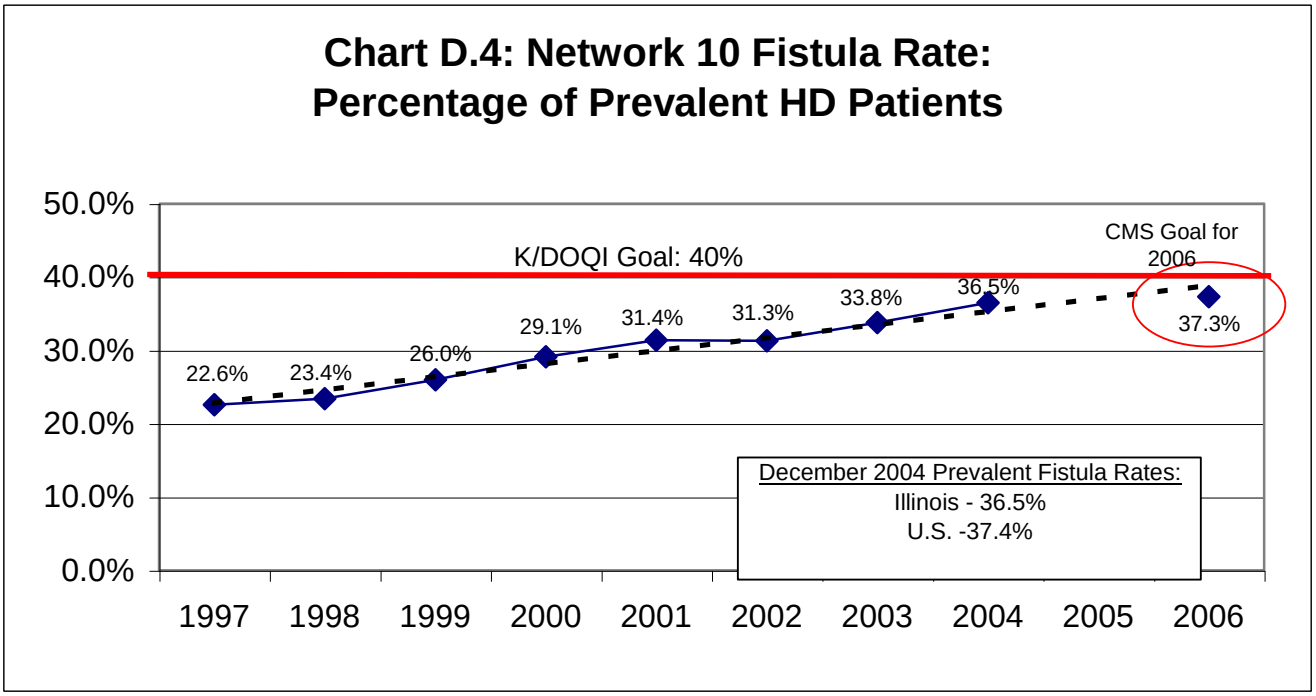


Chart D.4: Network 10 Fistula Rate:
Percentage of Prevalent HD Patients
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
K/DOQI Goal: 40%
CMS Goal for 2006
22.6%
23.4%
26.0%
29.1%
31.4%
31.3%
33.8%
36.5%
37.3%
December 2004 Prevalent Fistula Rates:
Illinois - 36.5%
U.S. -37.4%
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006

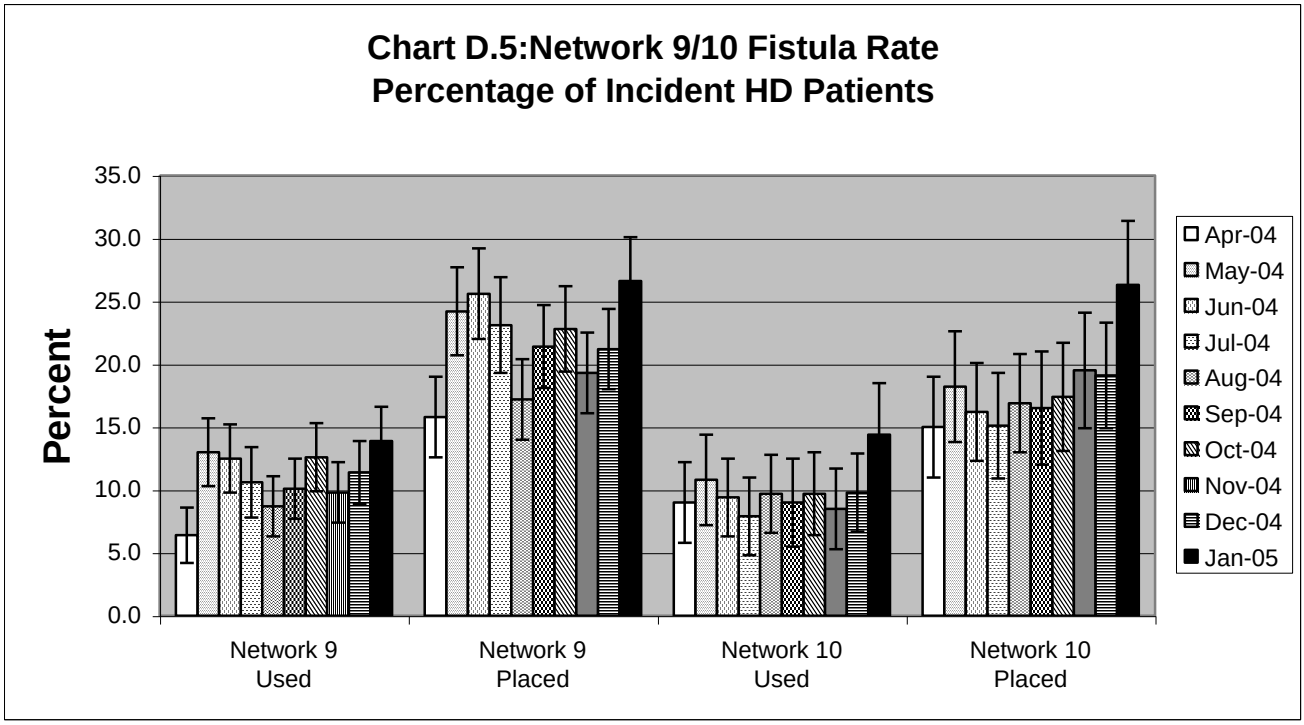


Chart D.5:Network 9/10 Fistula Rate
Percentage of Incident HD Patients
Percent
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
Network 9 Used
Network 9 Placed
Network 10 Used
Network 10 Placed
Apr-04
May-04
Jun-04
Jul-04
Aug-04
Sep-04
Oct-04
Nov-04
Dec-04
Jan-05

Development of Fistula First Quality Award: The Network established a Fistula First Quality Award to promote quality initiatives in the area of increasing arterio-venous fistulae (AVF) in the hemodialysis patient population. The award criteria were developed using the CMS National Fistula First Eleven Change Concepts and the K-DOQI guidelines. Application for this award was voluntary and was a way for any group or individual to be recognized if they so chose by providing performance processes and results in the area of placement and usage of AVF.

The goal of this award is to demonstrate performance above standards in the area of promoting AVF and vascular access management related to the Fistula First Initiative. Applicants are asked to present data that validates specific team processes used to realize improvement in the placement and usage of AVF. This is a performance award based on criteria that show rapid, sustainable improvement defined by a time-specific aim, quantitative measures to demonstrate improvement and identification of process changes that lead to improvement.

Any hemodialysis facility, vascular surgeon, or nephrology practice with an affiliation in Network 9/10 could apply for this quality award and the Network has committed to awarding this recognition on a yearly basis. This quality award may be given to any group or individual as defined by the applicant(s) that can identify specific quality processes leading to measurable and/or sustainable improvement. Applicants might include for-profit, not for-profit, public, private, and/or government agencies.

Announcement of the award will take place in early 2005. The awards will be presented at the Annual Nephrology conference in May 2005.

Award recipients will benefit by being recognized as a leader and promoter of quality of care for patients in the ESRD community, and will be highlighted on the Network Web site. It will also be expected that award recipients will share non-proprietary information with other facilities seeking education, and be willing to act as a mentor promoting the Fistula First initiative in Network 9/10.

Areas to be considered: The Network has been focusing on increasing fistulas with dialysis facilities and dialysis professionals for approximately one and half years through the Fistula First project. Out of discussions with nephrology and surgical professionals and facility needs assessments there are areas that must be considered as the Fistula First project continues, including:

- A CKD program must be developed to ensure timely referral to nephrologists and to improve incident fistula rates in Network 9/10.

- Vascular access management must be the responsibility of the nephrologists and/or medical director. Efforts in improving vascular access must be timely, focused and coordinated by a multidisciplinary team approach to vascular access placement and care.

- Vascular access surgeons should ensure that patients are evaluated and given a fistula if appropriate. Interested and motivated vascular access surgeons on the vascular access team can and will assist in spreading the word to the surgeon community.

- Large Dialysis Organizations (LDO) collaborations should be developed to assist in improving fistula rate outcomes.

Future initiatives: The Network has updated a plan to continue the Fistula First project and has identified areas that will help the dialysis facilities and the Network as a whole realize the goals set.

The Network will begin working on a CKD outreach initiative that will educate primary physicians, internists, and nephrologists. The Network will seek the assistance of the Quality Improvement Organizations (QIOs) in order to identify and communicate with hospitals and primary care physicians.

The National Kidney Disease Education Project will be used as a reference. A comprehensive program noting ways to slow the progression of kidney disease, planning and placing accesses during stage 3-4, and discussing EPO with the patient will be implemented. A "Tool Kit" will be developed and distributed by Network 9/10 to promote early referral (stage 1-2 CKD) and will provide education for the physician as well as the patient.

The Web-Ex Conference Call concept will be utilized more frequently in order to reach more of the community and become more efficient.

The Network 9/10 Web site will be a reference point with multiple articles, data collection tools, and monthly educational offerings. A chat room will be developed for questions, answers, and an information sharing area for the Fistula First initiative.

The vascular access Leadership Groups will continue to be followed and the Network will provide technical and secretarial assistance as needed.

The educational campaign will continue and will assist facilities in enhancing their vascular access programs. The educational campaign will become quarterly and will send articles, tools, and/or resources to key individuals in the community and will ensure that the Fistula First initiative remains the focus of quality improvement within dialysis facilities.

2. Dialysis Facility-Specific Kidney Transplant Referral Measures Project. During 2004, the Network began coordinating a special project in the area of referral for kidney transplantation on behalf of CMS. Entitled Dialysis Facility-Specific Kidney Transplant Referral Measures, the goal of the project was to examine the processes in place at the dialysis unit level to determine what process changes might be made to improve rates of referral for transplantation. A clinical team was first organized under the direction of Dr. Ashwini Sehgal of MetroHealth Medical Center/Case Western Reserve University in Cleveland, Ohio. A literature search was then conducted in the area of referral for kidney transplantation. A solicitation was made nationally for volunteers to sit on a Technical Expert Panel (TEP).

From the volunteer solicitation, the following multi-disciplinary panel was appointed:

Teri Arthur, MSW, LSW, University of Chicago
Francis Delmonico, MD, Harvard University - Massachusetts General Hospital
Jens Goebel, MD, Cincinnati Children's Hospital Medical Center
Richard Goldman, MD, Chair, RPA Quality Safety & Accountability Committee
Bonita Balkcom Guilford, Consumer Member
Lawrence G. Hunsicker, MD, University of Iowa Health Care
Mysore S. Anil Kumar, MD, Drexel University College of Medicine
J. Michael Lazarus, MD, Fresenius Medical Care North America
Keith Mentz, Nephrology, Inc.
Kim E. Phillips, MSN, RN, CCTC, University of Utah Solid Organ Transplant Services
Kris Robinson, American Association of Kidney Patients
Marlon Yu, RN, Southern California Permanente Medical Group
Erick B. Edwards, Ph.D., United Network for Organ Sharing

The panel met for the first time in October 2004 to discuss the findings of the literature search and to begin the review of current practices now commonly in place for referral to transplantation. Subsequent meetings were planned to take place in February and April 2005, with a final report due to CMS on June 30, 2005.

3. Special Study of Dialysis Treatment Delivered in the Nursing Home Setting. At the end of 2003, CMS requested that the Network assist in the development of a pilot study of dialysis treatment delivered in the nursing home setting. A private dialysis provider had volunteered to be monitored in providing this type of dialysis services in the Chicago area. Several meetings and conference calls were held on this proposal. By May, however, the volunteer dialysis provider had withdrawn from the pilot study and it the project was closed. Because of the interest generated, CMS asked the Network to coordinate a meeting for those interested in this form of dialysis delivery. On June 9 the meeting was held in Chicago. It was attended by representatives from CMS, the Illinois Department of Health and several providers of dialysis treatment. A summary of the meeting and recommendations made by the representatives attending was written and submitted to CMS.

4. Phosphorus Management Project. A Phosphorus Management education quality improvement project has been designed in Network 9/10. The purpose of this voluntary quality improvement project is to address obstacles to compliance with phosphorus control therapy through a combined dialysis facility staff and patient education program. This program will support the K/DOQI phosphorus guidelines, and is intended to minimize the amount of time required to integrate phosphorus management into dialysis facility practice.

The primary goal of this project is to utilize a rigorous education program for dialysis facility staff and patients with the intent to improve phosphorus management. The secondary goal of this project is to promote the use of guidelines for the management of phosphorus and to encourage communication of compliance-enhancing strategies to patients through an education program for the dialysis facility staff (physicians, dieticians, technicians, and nurses).

Specific learning objectives include increased awareness of the benefits of aggressive phosphorus management, increased use of learning materials with patients to promote compliance with phosphorus management regimen, and increased communication of compliance-enhancing strategies to patients.

In 2004, potential facility participants were identified, the project design was finalized, approval was granted by CMS, IRB approval was sought and IRB approval was received to begin the project.

An organizational meeting with the Network and the facilities who have volunteered to participate will take place in early 2005 and the project will begin in the second quarter of 2005.

The probability of this project achieving its objectives is high. The design of the project is similar to other quality initiatives the Network has directed with these initiatives yielding positive results. The project objectives of intense education and awareness will hopefully change behavior or at the very least will identify facility barriers that can affect change.

E. Focused Quality Assurance Activities - Cooperative Activities with Other Agencies

1. Network 9/10 distributed the 2004 Dialysis Facility Reports for the KECC in September 2004 to facility medical directors and administrators. The reports included standardized mortality ratios (SMR), standardized total admission ratios (STAR), and standardized transplant ratio (STR) for Medicare-only patients for 2000-2003.

2. Network 9/10 distributed a new publication, ***Network Connections***, to state surveyors and Quality Improvement Organization personnel in 2004. The newsletter is mailed quarterly. Topics include data regarding complaints and grievances, news about Network activities and timely topics.

3. Dr. Jerome Tokars of the CDC invited the Network to participate as a group in the Dialysis Infection Surveillance Network. This involvement was approved by both the Board of Trustees and the Medical Review Board. The Network sent information on the project to all units in the four-state area and invited them to join this voluntary project. A pool of facilities volunteered to participate; training was conducted via telephone conference call. At year-end the data collection was on-going. The goal is to form a Network pool of facilities to enter data into the CDC infection Web site.

4. Network 9/10 cooperated with the USRDS to complete the Cardiovascular Study data collection forms. Network staff traveled to facilities to collect data in early 2004. The data collection was completed and sent to the USRDS in May.

5. On April 4, 2004 an Illinois Department of Public Health conference call was held to discuss the patient complaints at a dialysis facility in Urbana, Illinois. On May 24, 2004, several members of the Network staff participated in a meeting in Urbana with CMS, the Illinois Department of Public Health, a local patient advocacy group, and a facility and the corporate staff to address patients' concerns about quality of care. On August 9, the Director of Patient Services attended another meeting with facility patients and staff, the outside advocacy agency, as well as the Illinois Department of Public Health.

F. Grievance Activities

1. 2004 Investigations. Investigations performed independently of a grievance are described in Section 4. Recommended Sanctions.

2. 2004 Formal Grievances. The Network used a variety of formats to make information available to the dialysis community to help resolve patient grievances and complaints, including the following activities:

- A Grievance Packet was made available to patients who preferred an established format.
- An article entitled "Grievances, Complaints, and Concerns in 2003" was published in *Progress Notes*, the professionals' newsletter of Network 9/10 and articles entitled "Would've, Should've, Could've: Do Not Leave Your Unit in a Huff " and "Patient Advocacy Groups: They Really Do Work" were published in ***Renal Outreach***, the patient newsletter of Network 9/10.
- Presentations were given to administrators, technicians, and social workers on conflict management.
- The Forum's Patient Services Coordinators Group developed an internal tool that can be used with non-adherent patients.
- A summary of the grievance process is available on the Network Web site and information about filing a grievance is also available on the patient Web site.

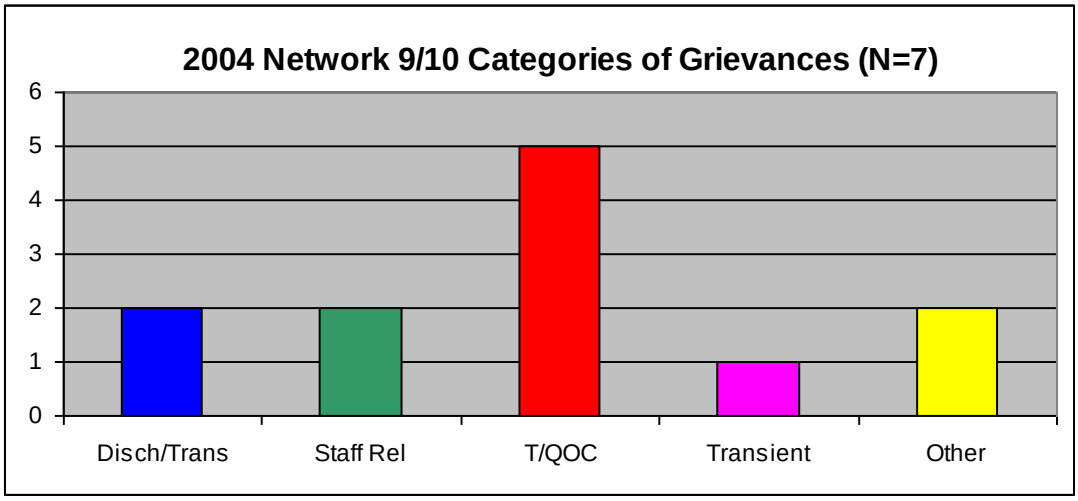
Network staff members routinely handle many requests for assistance directly from patients and their families, as well as facility staff members. These requests involve supplying information from various sources available from the Network, such as location of dialysis centers, help with transient dialysis, location of isolation stations, and specific federal regulations. The Network provides assistance to facilities to avoid discharging patients involuntarily, to develop effective behavioral agreements, and works with patients and facilities to resolve issues before they become grievances. In some instances, the Network may act as a go-between, making an initial contact for an individual who is seeking assistance. These contacts are tracked by the SIMS information system.

The complaints are reported through the CMS quarterly report format as investigations or grievances. Investigations are the result of complaints brought to the attention of the Network through a variety of means. Grievances are formal, written complaints filed by patients or their representatives, or by facility staff members. A special subcommittee of the Medical Review Board is designated to review grievances.

In 2004, seven grievances were filed by patients or their family members. Table F-1 shows the number that were referred as well as the number resolved.

Chart F.1: 2004 Formal Grievances				
Total Grievances	**Total Resolved**	**Total Unresolved**	**Total Referred & To Whom**	**Status of Grievances**
7 (1 had been reopened)	7	0	1 was also referred to the Illinois Department of Health 1 was referred to the Indiana State Board of Health 2 were referred to CMS	All closed

Chart F.2: This chart represents the seven grievances filed in 2004 (one was reopened). In many instances, one grievance will include several of the complaint categories listed: discharge/transfer, staff related, treatment/quality of care, transient, other.



GOAL 2: Establishing and improving partnerships and cooperative activities among and between the ESRD Networks, QIOs, state survey agencies, and ESRD facilities/providers, ESRD facility owners, professional groups, and patient organizations.

During 2004, the Network maintained ongoing cooperative relationships with a wide variety of organizations within the renal and Medicare communities.

A. Professional Affiliations.

The Network maintains an ongoing relationship with Health Care Excel, the agency which administers the quality improvement organization (QIO) for both Kentucky and Indiana. The

Network is represented on cooperative committees organized by Health Care Excel. The Assistant Director is a member of the Partners Promoting Quality (PPQ) committee for Health Care Excel.

The Network acts as a resource to the departments of health within Illinois, Indiana, Kentucky, and Ohio. Interactions between the Network and the state health agencies are ongoing. The Network continuously serves as an expert adviser for the technical aspects of dialysis, a resource for complaints, grievances and facility concerns, and provides Network developed resources when requested. During 2004, a group of Indiana dialysis facility administrators continued to meet regarding citations issued by the state surveyors concerning the use of unlicensed personnel in their facilities. Discussions were held with the Indiana Health Professions Bureau regarding the certification process. At year-end it appeared the goal seemed to be geared toward some degree of certification of technicians, however, a final ruling was not made.

The Network also provides resources and contacts with other dialysis agencies, such as the National Kidney Foundation and its affiliates, The University of Michigan Kidney Epidemiology and Cost Center, the United States Renal Data Service, and the United Network for Organ Sharing. The relationship between state health agencies and Network 9/10 continues to develop in a collaborative manner.

The Director of Patient Services participated in a discussion on involuntary patient discharges at the Kentucky Social Workers' Meeting on March 12, 2004.

On April 1, 2004 the Director of Patient Services presented an all day workshop to the Ohio Davita Regional Social Workers on conflict management and related topics.

The Director of Patient Services presented sessions for administrators and nurses at the Ohio Regional Renal Association conference on April 29 and 30, 2004. The topics were conflict management, professionalism, and handling anger.

The Director of Patient Services is a member of the Toolbox Development Steering Committee of the Decreasing Dialysis Patient-Provider Conflict (DPC) Project. The subcommittee met on March 23, and May 4 and 5, 2004 to discuss and develop the poster and parts of the toolkit. Additional work took place by conference calls and emails. The Director of Communications assisted in the development of DPC poster.

Network staff participated in a Human Factors Training Workshop July 15 and 16, 2004 with other Networks and QIOs.

Network Staff presented at the Indiana Social Workers meeting on August 27, 2004 on the topics of conflict management and professionalism.

Network staff participated in the "Caring Through the End" conference and the pre-conference Professional Development Program sponsored by the Mid-Atlantic Renal Coalition in December 2004.

The Director of Communications worked with the New Media Department, School of Informatics at Indiana University at Indianapolis throughout the year on the development of the multimedia product, *The Uninvited Guest*.

The Director of Communications participated in an evaluation conducted by the Center for Health Quality Care to evaluate the efficiency and effectiveness of the National Kidney Disease Education Program (NKDEP) educational pilot projects.

B. Patient Interaction in Network Activities.

To promote patient input and participation in the Network, the following activities were conducted during 2004.

- New patients were informed about the Network through a New Patient Packet that the Forum distributes to new patients.
- Patients participated on Network committees including the Board of Trustees and the Medical Review Board.
- Patients participated in the Robert Felter Memorial Award program, both in choosing a recipient for the facility award as well as the patient award.
- Throughout the year, information about the PLC and Patient-to-Patient Program as well as other patient resources were sent to patients and staff who expressed an interest in becoming involved with any of the programs.
- Patients participated in the development of the pediatric training tool for staff, family multimedia project, the calendar for dialysis staff, and the brochure on fistula placement.

C. Community Outreach Activities.

The Renal Network acts as a clearinghouse to provide information concerning ESRD technology and treatment advances to ESRD professionals, patients, and other interested persons and organizations. Information received or generated by the Network was disseminated to the appropriate individuals at the discretion of the Executive Director or other appropriate staff persons. During 2004 information was distributed Network-wide in the following manner:

1. Newsletters, *Renal Outreach* and *Progress Notes*.

The Renal Network publishes two newsletters for the different renal audiences newsletter in the four-state area. ***Renal Outreach*** is directed toward the community of ESRD patients, but ESRD professionals and members of the renal community receive the newsletter, as well. In total, about 10,000 copies are distributed with each mailing. ***Progress Notes*** is written for the community of renal professionals; about 5,000 copies are distributed with each mailing.

Renal Outreach provides a continuing means of communication to all patients within Network 9/10. It contains information on new therapies, rehabilitation, medications, nutrition, exercise, and general topics of interest, as well as news of Network 9/10 and Patient Leadership Committee activities. Patients are encouraged to submit their ideas for articles and to write articles for the newsletter. Each newsletter contains at least one article written by a patient or family member. ***Progress Notes***

contains updates on Network activities and nephrology news of national interest for the renal professional.

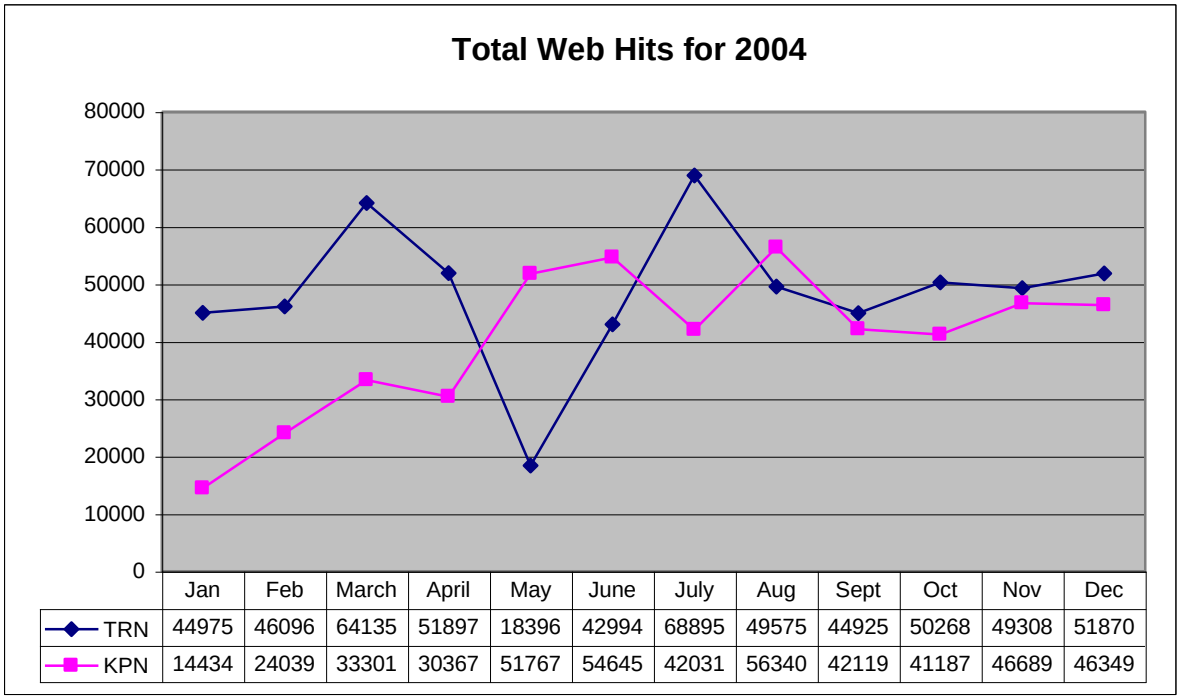
2. Network 9/10 Handbook - Policies and Procedures.

The Network 9 /10 Handbook was developed to ensure all member facilities are continuously apprised of Network 9/10 policies and procedures as approved by Network 9/10 Coordinating Council. The Handbook is updated periodically as policies are developed or are amended; materials are posted to the Network Web site at www.therenalnetwork.org, in the policies and guidelines section.

3. Web Sites

The main Network Web site is found at the www.therenalnetwork.org. This site is intended to provide information about Network 9/10 activities and links to other resources in the renal community. The front page is updated monthly with news. Policies, procedures, and selected data items are added as they become available.

A second Web site is devoted to issues of interest to patients and family members. This site, www.kidneypatientnews.org, contains articles and information with a patient focus. There are links to other sites as well as the ability to download and/or order Network materials. It is updated on a regular basis.



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
TRN	44975	46096	64135	51897	18396	42994	68895	49575	44925	50268	49308	51870
KPN	14434	24039	33301	30367	51767	54645	42031	56340	42119	41187	46689	46349

4. New and Updated Resources: During 2004, resources were added and/or updated, including the following:

- *Ease the Ouch!* brochure
- *The Uninvited Guest,* CD-Rom
- *Treatment Options* Poster
- *Talking Transplant* brochure
- 2005 Network Calendar: Conflict Management: A Leadership Perspective to Growth Through Problem Solving
- Renal Outreach
- Progress Notes

5. Educational and Cooperative Activities:

- The Network collaborated with the New Media Department, School of Informatics, at Indiana University-Purdue University at Indianapolis for the development of a CD-ROM with an animation and individual interviews on issues and concerns of renal patients and their families.

- Materials were provided for 14 events including health fairs and workshops/training programs.

- CMS booklets on emergency planning for facilities and patients were sent to facilities as requested. A detailed section on emergency planning was developed for the TRN Web site.

- The Network collaborated with the Indiana Alzheimer's Association and Indiana University Hospitals to present the conference "Journeys through the Maze of Dementia" on November 4, 2004.

- Information was sent to all four state vocational rehabilitation offices within Network 9/10 to provide information about the Network and to learn about their concerns in working with ESRD patients. This information was shared with facilities through the *Progress Notes*. Web site information was augmented to include access to local vocational rehabilitation offices.

- Information was gathered at the Network's annual conference from administrators and social workers regarding their vocational rehabilitation programs and their concerns on the topic and this information was shared with the PLC Vocational Rehabilitation Committee to use in planning new activities in rehabilitation for facilities.

- A resource tool for vocational rehabilitation was developed with the assistance of the Patient Leadership Committee to share with facilities to assist with following patients who receive rehabilitation services through their local vocational rehabilitation office.

- Educational pamphlets and resources were sent to patients and staff when requested that supported rehabilitation goals, such as activities to promote quality of life, exercise tips, journaling suggestions, tips for sleeping well, and financial resources.

- Articles related to patients working, the benefits of employment and how to find resources to go back to school or work were made available to patients and staff through the patient newsletter as well as on the Network's web site.

- The Network was represented and provided resources at the People First conference on August 17, 2004 that was held in Ohio.

- The Network participated in Forum-sponsored activities and meetings.

- On September 30 and October 1, the Network sponsored the annual Fall Pediatric Renal Symposium. This is a two-day educational offering which is planned by a committee of Pediatric Renal Group members. Topics included: transplantation, transitioning from pediatric to adult dialysis settings, boundary issues for patients and staff members, fundamentals of education and learning and adolescent nutrition. Approximately 100 representatives from pediatric centers within the Network participated over the course of the two days.

6. Nephrology Conference

In combining its roles as an information clearinghouse and a professional renal association, The Renal Network sponsors the Nephrology Conference each year. The 2004 Nephrology Conference was held on June 10 and 11 at the Sheraton Hotel and Towers in downtown Chicago. This annual event is designed to allow members of the Network to come together to conduct Network business while providing educational opportunities and allowing for the exchange of ideas among members of the renal community in Illinois, Indiana, Kentucky and Ohio.

The goal of the Conference is to offer a multi-disciplinary scientific seminar, individual meetings of different professional groups, and to provide awards to those individuals and facilities that have excelled in meeting of Network goals during the year. These activities are planned in conjunction with the meeting of the Network Coordinating Council. The chart below shows attendance rates for 2001 - 2003.

Chart C.2: 2004 Nephrology Conference – ESRD Network 9/10

Meeting	Vendors	Vendor Reps	MD	Admin	RN	Tech	SW	RD	Neph Update	TOTAL Registrations
2004	**37***	**120**	**40**	**108**	**157**	**46**	**61**	**54**	**328**	**914**
2003	**35***	**121**	**37**	**111**	**133**	**52**	**97**	**73**	**304**	**928**
2002	**33***	**N/A**	**47**	**130**	**136**	**63**	**53**	**54**	**258**	**741**
2001	**35***	**N/A**	**42**	**86**	**132**	**64**	**78**	**81**	**212**	**695**

** Figure not included in TOTAL column.*

The Conference is organized by the Conference Program Planning Committee to ensure input from the Network members. Additionally, Network-wide professional groups for administrators, social workers, technicians and registered dietitians were formed to facilitate planning individual sessions for these disciplines. The Network works in conjunction with the American Nephrology Nurses Association to plan a full-day session for nurses and sponsors a certification exam for technicians with BONENT.

All programs are designed to provide continuing education credits for participants, to enhance the value of these offerings to Network members. To further integrate the Conference into the renal community, businesses dealing in renal products are invited to exhibit during the event. This serves the dual purpose of providing useful information to conference participants while underwriting the event through these sponsors.

Topics for presentations included:

- State of the Network and Collaborative Initiatives
- The Crisis of Cardiovascular Disease in Dialysis
- Diagnosing and Treating Hypertension in Hemodialysis Patients
- Abnormal Mineral Metabolism and Cardiovascular Disease in CKD
- Anti-Oxidants and Chronic Inflammation in ESRD: The Role of Lipids
- Vascular Access: Our Biggest Challenge
- Native AV Access as the Optimal AV Access: Surgical Options and Considerations
- Back to the Basics: Increasing the Use of AV Fistula Use
- Imaging and Intervention to Improve Native Fistula Use
- AV Access – Surgeon and Nephrologist Perspectives
- Management of Secondary Hyperparathyroidism
- Dialysis Outcomes and Practice Patterns Study
- Scientific Presentations (10 presentations by nephrology fellows)
- Hypertensive Renal Damage
- Modulatory Effects of Stasis on Rho GPTases in Diabetic Nephropathy
- Contemporary Management of Kidney Stones
- Hexokinases and the Interface Between Metabolism and Cell Survival
- Regulatory and Legislative Updates Impacting the ESRD Community
- Preservation of Vascular Access: The Master Cannulator Program
- Coaching Strategies for Administrators and Managers
- Cannulation Camp
- Issues in Peritoneal Dialysis
- Access initiative - West Suburban Dialysis Center
- Update on Diabetes
- Salvaging Access
- Documentation for Technicians
- Where Were You When the Lights Went Out? Disaster Preparedness and the Great Northeast Blackout of 2003
- Cardiovascular Complications of CKD
- Gastroparesis: Where We Are Now
- Icodextrin – A Non-Glucose Dialysate
- Management of Secondary Hyperparathyroidism
- Renal Osteodystrophy: Pathogenesis, Consequences and Management
- Talking The Hard Talk: Grief Therapy for Patients and Professionals
- Social Security and ESRD
- Utilization of Creative Arts Therapy with Dialysis Patients
- Educating Our Patients on Treatment Modality: Transplantation and Peritoneal Dialysis

The Network recognizes achievement among its members by presenting awards for individuals who have made outstanding contributions to the Network, and also who have gone above and beyond the minimum to meet network reporting requirements, both in data and quality assurance. During 2004, collection of anemia and adequacy data was suspended until a CMS approved data collection tool becomes available. The Network was able to continue collecting vascular access data through the Fistula First data collection tool. The chart on the next page illustrates the number of facilities that were recognized for vascular access achievement through the Network 9/10 Quality Awards Program.

Chart C.3: 2000 – 2004 Vascular Access Quality Awards Recipients Network 9/10

Network Quality Award	2000 # (% total)	2001 # (% total)	2002 # (% total)	2003 # (% total)	2004 # (% total)
Fistula Rate ≥ 40%	**23 (6%)**	**24 (6%)**	**70 (16%)**	**56 (12%)**	**135 (27%)**
Catheter Rate ≤ 10%	**10 (3%)**	**6 (1%)**	**16 (4%)**	**3 (.6%)**	**13 (2.3%)**
Sustaining Member: Hemodialysis Programs	**8**	**17**	**25**	**25**	**15 (Fistula rate for 3 consecutive years)**

7. Other Activities.

The Network has developed and maintained email list services for different audiences, including physicians, administrators and social workers. These list services are used as warranted to provide an expedient and inexpensive means to reach a large audience with information, such as news on a variety of topics, including FDA recalls, Network nominations process and election, Network meetings, and quality initiatives.

As events warrant, informational bulletins are sent to the appropriate individuals via regular mail. These releases of information may be sent to committee members, council members, professional disciplines, patients or other related organizations. If necessary, a general release may be sent to all interested parties.

News of general interest is included in the newsletters of Network 9/10 to ensure that the membership is kept informed of activities on a continuing basis. Network 9/10 maintains a mailing list, by category, on computer to facilitate clearinghouse functions. This listing is continuously updated to provide an efficient mailing process.

Additionally, Network 9/10 responds to individual requests for information as these are received. The requests come from a variety of individuals, from dialysis patients and family members, renal professionals, students, researchers, and planning organizations and/or dialysis corporations.

GOAL 3: Supporting the marketing, deployment, and maintenance of CMS approved software.

ESRD Network 9/10 has been an active partner in promoting CMS programs for data collection, specifically the VISION software package. During 2004, Network 9/10 trained 39 dialysis facilities. This number represents about 20% of eligible dialysis units, i.e., independent, non-large dialysis provider dialysis units. At year-end, 63 dialysis facilities were entering data through the VISION software. A total of 2,807 events had been received, 1,096 2728 CMS Medical Evidence forms and 728 2746 CMS Death forms.

GOAL 4: Improving data reliability, validity, and reporting between ESRD facilities/providers, Networks, and CMS and other related agencies.

A. Facility Compliance

At the beginning of 2004 all dialysis and transplant facilities within the Network were participating as required by CMS and The Renal Network. At year-end 2004, all dialysis facilities within the Network 9/10 area were participating as required by CMS and The Renal Network.

B. System Description.

The data processing system is based on the generation of CMS mandated forms and a Network tracking report by ESRD facilities. These forms provide the necessary information and updates that assure the accuracy of the data system.

CMS Medical Information System (MIS) Forms that are processed through the Network office include:

- CMS 2728 - Chronic Renal Medical Evidence Report
- CMS 2744 - ESRD Facility Survey
- CMS 2746 - ESRD Death Notification

As these forms are received in the Network office, they are input into the SIMS database, the CMS logging program, and a compliance program. This information is forwarded to CMS.

The Network 9/10 Data Department routinely completes the following activities:

- Handling daily receipt of MIS forms and logging forms on the Network computer.
- Verifying information on MIS forms.
- Monthly review of facility compliance goals for forms submission.
- Input of MIS forms and tracking forms on the SIMS patient information system.
- Processing of CMS generated facsimile forms.

C. Compliance Reporting.

The SIMS program tracks compliance for forms submission and completion by each facility. The program generates a report showing each facility, which forms were received, and whether or not they were compliant. It also generates a master report showing compliance rates for all facilities within the Network. Compliance rates are reviewed monthly by Network staff. Quarterly, compliance reports are generated and sent to the facilities. The Medical Review Board routinely reviews compliance rates for those facilities which fall below the CMS goals at their quarterly meetings.

D. Patient Tracking System.

The data system has unlimited capability to collect information on ESRD patients. Currently, more than 33,000 active and inactive patient listings are in the system. Information collected on each patient includes:

- Full Patient Name
- Social Security Number
- Medicare Number
- Demographic Information
- Patient Address
- County of Residence
- Transfer Information and Date
- Initial and Subsequent Providers
- Modes of Therapy
- Primary Diagnosis and Co-morbid Conditions
- All Types of Changes in Patient Status
- Transplant Candidate Status
- Vocational Rehabilitation Status
- Number of Treatments Performed
- Date of First Dialysis
- Current Status
- Cause of Death
- Clinical Performance Measures

After the data are entered, they are then available for statistical manipulation. The data tables contained in this report were generated through the Network data system as well.

Validation activities include routine investigations of accretions and notifications provided by CMS. When corrections are found they are updated directly in SIMS. A three percent sample of 2728 forms is drawn quarterly and reviewed for accuracy and completeness.

E. Community Outreach Through Data

Network 9/10 uses its database as a constant source of information on the ESRD population for the renal community. During 2003, Network 9/10 filled requests for Statistical Report data, for ZIP Code and county data, for facility demographic profiles, for SMR data, for core indicator data, and compliance data. Data requests are received continuously from a variety of interested parties, including:

- Requests from facilities for information on their own programs. Often these requests ask for historical information to allow the facility to assess trends. SMR data was also released which displayed a facility's ratio compared to the Network. This allows the facility to make comparison of its ratio with its peers.

- Requests from organizations attempting to establish new ESRD programs within a given area, or from current providers who are attempting to expand their services. Data often requested includes capacity and utilization figures, and patients by residence, divided by county or ZIP Code. (All patient data released is done within the confines of established CMS confidentiality rules.)

- Requests from state health planning agencies to assist them in assessing the need for ESRD service when reviewing Certificate of Need (CON) applications.

- Requests from researchers in a variety of interests, such as patients dialyzing by modality, by diagnoses, demographic information, and transplantation.

4. SANCTION RECOMMENDATIONS.

No sanction recommendations were made during 2004. However, instances arose where Network intervention was needed on an ongoing basis to assure the care within the dialysis unit was adequate.

1.) During 2004 the Network continued to monitor some facilities in Ohio and its medical director regarding quality of care issues. The Network became aware of problems in 2003.

2.) The CMS Project Officer became involved in a grievance filed against a facility for a wrongful discharge of a patient. The patient was given an immediate discharge and was unable to find another facility to accept him possibly due to suspected HIPAA violations. The facility also was uncooperative with the Network request for records necessary to conduct our investigation.

5. RECOMMENDATIONS FOR ADDITIONAL FACILITIES

Each year through the patient tracking system, The Renal Network conducts a review of facility operations. This information is made available to the provider community for many uses, including estimating need for additional services.

From this report the following information is available:

- Services Rendered: describes each facility by area of location within the Network and the modes of therapy offered.
- Current Operations: shows the number of stations currently operating at each dialysis facility within the Network.
- Patient Capacity by Facility: calculates the total number of patients that could dialyze at each facility based on the number of shifts and stations available at that facility.
- Utilization: identifies the actual utilization of each dialysis facility at year-end 1999.
- Pediatric ESRD Facilities: shows the number of stations currently operating at each pediatric dialysis facility within the Network.

6. DATA TABLES