Renal Network of the Upper Midwest Inc.
Network 11 Annual Report
2010

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Dear Colleagues:

This 2010 Annual Report summarizes Network 11's work with ESRD providers and others to assess and improve care for people with chronic kidney disease. We should all be proud of these accomplishments, especially the following highlights.

Met Arteriovenous Fistula (AVF) Goal
Our Network achieved a 56.1% AVF prevalence rate as of March 2011, a 2.7% improvement from March 2010. This laudable improvement met the CMS AVF goal set for Network 11. Quality improvement activities included working with all dialysis facilities and especially 161 facilities that were not on pace to meet their facility-specific AVF goal. In addition, 16 on-site visits and 4 off-site reviews were conducted, webinars were convened, and 1,600 reports were distributed.

Improved Anemia Management
Network 11 continued to focus on anemia management. Please note the following results as of Q4 2010. Of the 22,125 dialysis patients in 421 dialysis facilities in Network 11 that were included in the Elab Project for Q4 2010:

- Only 7.5% of all hemodialysis (HD) patients had a mean hemoglobin < 10 gm/dL
- 68.6% of all HD patients achieved a mean hemoglobin in the target range of 10-12 gm/dL
- 23.9% of all HD patients had a mean hemoglobin > 12 gm/dL.

Completed Other Special Initiatives

- The Upper Midwest Fistula First Coalition, coordinated by Network 11, developed and distributed the vascular access assessment posters for use at each dialysis station in Network 11. We also developed and distributed a vascular assessment checklist, suitable for individual patient charts.
- Three different collaborative groups of dialysis facilities worked with Network 11 on reducing missed dialysis treatments, improving tracking and reporting of vaccinations rates, and completing comprehensive Quality Assessment and Performance Improvement Programs. Each project goal was met.

Minimized Involuntary Discharge of Patients
Network 11 works with providers to address difficult patient situations and to prevent involuntary patient discharge for noncompliance, so it is especially rewarding to note the following results.

- The overall involuntary patient discharge rate dropped to 0.78 discharges per 1,000 dialysis patients, the lowest rate in Network 11's recorded history.
- Only two patients were involuntarily discharged for noncompliance in 2010, the lowest number in Network 11's recorded history.
- Involuntary discharges were averted in 144/163 (88%) of contacts regarding discharge, noncompliance, disruptive, and abusive situations.

Used Data to Help Inform Decision Making

- Processed over 13,800 patient-specific forms and nearly 6,000 changes to the ESRD provider directory.
- Worked with CMS on the transition to CROWNWeb.

Thank you for working with Network 11. We hope that you will join our Annual Meeting on October 14, 2011 in Detroit, MI, and please visit the Network 11 Website for more information at www.esrdnet11.org

Sincerely,

Thomas Nevins, MD
President, Network 11

Acknowledgments

Our thanks go to the many individuals in all
Renal Network 11 facilities who contributed timely and accurate
data throughout 2010. Your cooperation makes the information
in this report possible and we sincerely appreciate your efforts.
Thank you!

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Executive Summary
2010 Accomplishments of Renal Network 11

Fistula First Project

- Achieved 55.6% arteriovenous fistula (AVF) prevalence rate among hemodialysis patients in Network 11 as of December 2010.
- Increased the number of AVF patients to 11, 304 as of December 2010.
- Conducted the following activities to increase AVF rates.
- Monitored data monthly to identify if facilities were on pace to meet their facility-specific goal by December 2010.
- Worked with 161 facilities that were not on pace to meet AVF goals and assisted development of effective Quality Improvement Plans.
- Distributed quarterly facility-specific progress reports to Network 11 facilities participating in the Fistula First initiative, totaling over 1600 reports in 2010. Conducted four off-site and 16 on-site medical review visits to dialysis facilities.

Additional Quality Improvement (QI) Highlights

Network 11 offered technical assistance in the following three QI collaborative projects, and generated resources and quality improvement reports, such as the Network 11 Composite Quality Report. For more detailed descriptions, please see the QI section of this report.

1. **Dialysis Adequacy/Missed Treatments.** Network QI staff worked intensively with nine facilities on identifying best practices in reducing the occurrences of missed dialysis treatments.
2. **Immunization.** Network QI staff partnered with nine facilities to increase the usage of an electronic data tool to track and report immunization rates more accurately.
3. **Quality Assessment and Performance Improvement (QAPI) Programs.** Network 11 visited twelve dialysis facilities to develop and implement a comprehensive Quality Assessment and Performance Improvement Program regarding vascular access.

- **Network 11 has compiled composite quality reports** for dialysis facilities that include comparative results for the following indicators:
    - Overall ranking (1-420 dialysis facilities in Network 11).
    - Individual indicator rankings.
    - Percent of patients meeting Medical Review Committee recommended treatment goals.
    - Elab results for anemia management, dialysis adequacy, bone and mineral metabolism.
    - Vascular access results of AVF used and placed, AVG, catheters over 90 days, and trends.
    - Standardized mortality ratio data including data on deaths due to infection.
    - Hospitalization, transplantation, and other descriptors including percent of nursing home patients, co-morbid conditions, influenza vaccination, and involuntary patient discharge.

- **Achieved the following Network 11 Elab results in Q4 2010.** For more information about how these results compare over time and among other Networks, please see the QI section of this report.
  - 93.7% of patients have Kt/V ≥ 1.2
  - 89.8% of patients have URR ≥ 65%
  - 7.5% of patients have a mean hemoglobin < 10 gm/dL
  - 68.6% of patients have mean hemoglobin 10-12 gm/dL
  - 23.9% of patients have a mean hemoglobin > 12 gm/dL
  - 82.7% of patients have an albumin ≥ 3.2/3.5 gm/dL
  - 58.5% of patients have mean phosphorus 3.5-5.5 mg/dL
  - 50.1% of patients have both mean phosphorus 3.5-5.5 mg/dL and mean calcium 8.4 - 10.2 mg/dL, representing the best percentage among Networks nationally.

- **Updated Medical Review Committee Recommended Treatment Goals**
  - **Anemia Management-** The new guidelines recommend that facilities strive for target hemoglobin of 10-12 gm/dL. In addition, the less than 10 and greater than 13 thresholds have been lowered to < 8% of patients with hemoglobin concentration of < 10 gm/dL and < 8% of patients with hemoglobin ≥ 13 gm/dL.
  - **Hemodialysis Adequacy-** Increased the MRC Recommended Guideline and the Best Practice Guideline for hemodialysis adequacy to 90% and 95% respectively. In addition, the recommendation for home hemodialysis patients on frequent dialysis (≥ 4 times per week) is increased to 85%.

- **Assisted providers in emergency preparedness and response**
  - In spring 2010, during the Red River flooding, NW11 worked with dialysis facilities, state health departments, and other agencies to prepare for impending flooding potentially impacting 13 facilities.
  - Distributed an emergency preparedness toolkit to all new dialysis facilities in Network 11.
  - Network 11 distributed a patient education resource for emergency preparedness. This tool includes emergency information, nutrition information, and important numbers to keep during an emergency.
  - Distributed a toolkit for both local disaster and state level agencies to assist local disaster agencies, state disaster agencies, and dialysis facilities to collaborate in their emergency planning.

- **Coordinated the Upper Midwest Fistula First Coalition**
  - The Coalition developed an AVF Access Assessment Poster for display at each facility's dialysis station to guide both patients and staff to assess the access for functionality and complications.
  - The Coalition also developed an Access Assessment Checklist to provide facilities with a process for both assessing the vascular access each treatment, and providing monthly summary of general access condition.

Consumer Services Accomplishments

- Responded to 414 concerns from patients, families, and ESRD facility personnel.
- Averted 88% (144/163) of potential involuntary patient discharges.
- Published two editions of Common Concerns, Network 11's patient newsletter, and mailed them directly over 43,000 ESRD Patients.

Information Management Accomplishments

- Processed a total of 13,818 CMS patient-specific forms.
- 8,205 were Medical Evidence forms
- 5,613 were Death Notification forms.
- Reconciled all 445 ESRD facility surveys by March 31, 2011.
- Made 99,930 modifications to SIMS data tables in 2010.
- Processed 4,973 Patient Activity Reports.
- Updated the ESRD Provider Directory by recording 6,525 updates in 2010, an average of 544 per month.

Administrative Accomplishments

- Convened an annual educational meeting in Saint Paul for 200 meeting participants.
- Maintained a professionally diverse and actively engaged Executive, Medical Review, and Consumer Committees.
- Increased efficiencies and reduced costs whenever possible.
- Responded to 400 requests for information.
- Retained a talented and motivated Network staff of 12, serving 454 facilities and about 43,000 patients.

Other Important Statistics for 2010

- 454 ESRD providers served about 43,000 ESRD patients in Network 11.
- 7,562 new patients began treatment in 2010 at Network 11 ESRD facilities.
- 1,487 kidney transplants were performed by centers in Network 11.
- Network 11 leads the nation in the number of renal transplants performed; over 50% above the average number nationwide.
- With 204, we have the largest number of independent dialysis facilities in the country.

Introduction

Network Description

ESRD Program Overview

General Population Demographics

ESRD Population in Network 11

Network Structure

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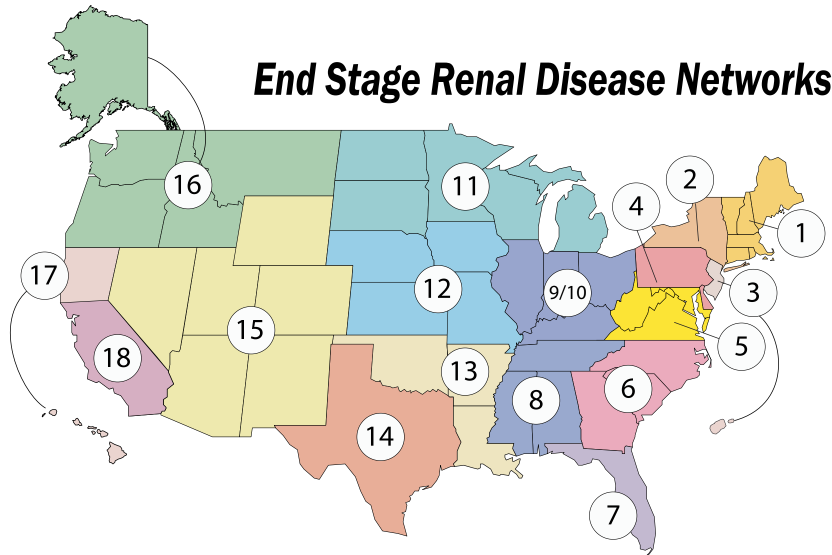
Internal Quality Program

Business Continuity Plan

ESRD Program Overview



ESRD Program
Created in **October 1972** (Section 2991, Public Law 92–603). The legislation entitles Medicare benefits to nearly all individuals with ESRD, regardless of age. Medicare trust funds reimburse costs of kidney dialysis and transplant services provided by Medicare–certified ESRD facilities. Effective since July 1973, the program is administered by CMS.

Conditions for Coverage
On **June 3, 1976**, the "Conditions for Coverage of Suppliers of ESRD Services" were published in the Federal Register. These rules and regulations address the subjects of facility qualification requirements, certification procedures, minimal utilization rates, ESRD Networks, Coordinating Councils, and Medical Review Boards.

Program Amendments
On **June 13, 1978**, Congress enacted Public Law 95–292 to improve the ESRD Program, cost–effectiveness, and quality of ESRD care.

ESRD Networks
Regional ESRD Networks were also created in 1978 to help organize and administer the provision of ESRD services.

National Networks
Today, 18 regional Networks serve the nation. Each is governed by a Council of representatives from ESRD facilities in the area.

Network 11
The Renal Network of the Upper Midwest, Inc. serves over 43,000 ESRD consumers in 456 facilities. Network 11, through its Elab project, also receives and analyzes patient laboratory data from all 18 Networks and returns over 5000 facility-specific reports.

Conditions for Coverage
On October 14, 2008, new Conditions for Coverage became effective.

Changes in Reimbursement for ESRD Providers
In July 2010, CMS announced two important changes regarding Medicare reimbursement for ESRD Providers; the Proposed Payment System (PPS), and the Quality Incentive Program (QIP).

1972 **1976** **1978** **2008-2010**

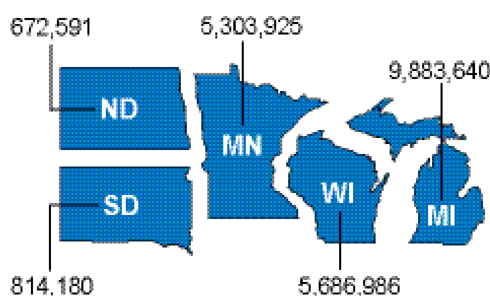
General Population Demographics[1]

Population Density and Geography

Over 22.2 million people live in the Network 11 five–state region, which is a surprise to many people who assume that the Upper Midwest is a mostly rural and sparsely populated area. Only 29% of the population lives in a rural area. The majority of people in Network 11 live in major metropolitan areas, including Detroit, Milwaukee, and Minneapolis–St. Paul.

Network 11 covers more than 350,000 square miles and spans 3 time zones. From extremely cold winters to hot summers, the states in Network 11's region experience great seasonal variability and often times, inclement weather. This can make travel in the area very difficult. The extreme cold can be dangerous, especially for vulnerable populations such as the elderly.

Figure 1. General Population by State, 2010 Census Data



Racial and Cultural Diversity

The region served by Network 11 is culturally and racially more diverse than one might think. The state of Michigan ranks 10th nationally for African American population. The city of Detroit, Michigan is home to an 82% African American population. In Native American population, all five of the states in Network 11 are in the top half. These are notable numbers as African Americans and Native Americans have a higher incidence of kidney disease.

Age

Four of the 5 states in Network 11 are above the national average of 12.5% for population over age 65. Two states in Network 11 are among the top 10 states with the highest percent of population over the age of 65—those being North Dakota and South Dakota, which ranked 7th and 8th in the nation, respectively (April, 2008).

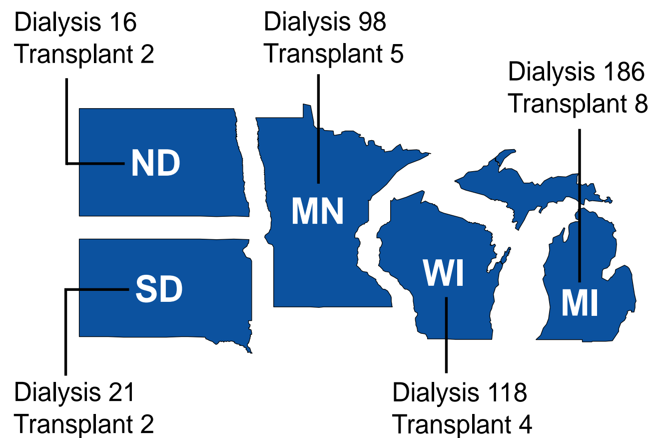
1. Sources for all data are from the 2010 Census, U.S. Census Bureau, unless otherwise noted. The most recent data available (including estimates) were used .

ESRD Population in Network 11

Facility Growth

Nationwide, there is a significant regional difference in the growth of ESRD service providers. In 2010, net increases in providers by Network ranged from -1 to 9, with Network 11 in the top six at 5. In the past five years (2006–2010), the average number of new facilities opening per year in Network 11 has been 17. As of May 2011, there are 460 ESRD facilities in Network 11 (439 dialysis and 21 kidney transplant centers).

Figure 1. Number of Dialysis and Transplant Facilities in Network 11, by State, May 2011



A unique feature of Network 11 is the volume of facilities that are independently owned—that is, not owned by a Large Dialysis Organization (LDO) such as FMC or DaVita. In Network 11, 46% of dialysis units are independent and not affiliated with a LDO (204 independent units of 439 total dialysis facilities). This unique mix has offered diversity and creativity, but also poses extra challenges for projects such as Fistula First, the Elab Project, CROWN Web, and facility-specific outreach activities.

New ESRD Patients

In 2010, 7,562 patients began ESRD therapy at ESRD facilities in Network 11, and 98% (7,448) of these were Network 11 residents. See data tables for incidence by age, diagnosis, race, and sex.

All Patients (Residents and Non-Residents)

In 2010, Network 11 providers served 42,980 people with ESRD. Of this population, 44% (18,739) are living with a functioning kidney transplant performed by a Network 11 transplant center. The remaining 56% (24,241) are dialyzing at home or in Network 11 facilities. See figure 2.

Figure 2. ESRD Prevalence in Network 11, 12/31/2010

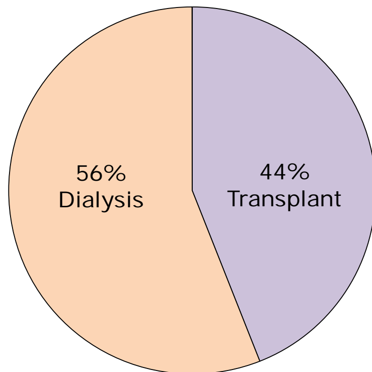


Figure 3 notes an interesting difference in patterns of ESRD duration by treatment modality. Most patients on dialysis—80%—have had ESRD for five years or less, whereas 71% of transplant recipients have had ESRD for more than five years.

Figure 3. Network 11 Patients: Number of years with ESRD, by current modality

# Years with ESRD	Current Dialysis	Current Transplant
<1 Yr	24	2
1-5 Yrs	56	27
6-10 Yrs	13	29
11-20 Yrs	6	31
21+ Yrs	1	11

Dialysis Residents

There were 24,241 Network 11 residents dialyzing in Network 11 as of 12/31/2010. A total of 195 non-residents were dialyzed in Network 11 as of 12/31/2010. For detailed information about age, diagnosis, race, and sex, please refer to the data tables.

Self-Care Dialysis Patients

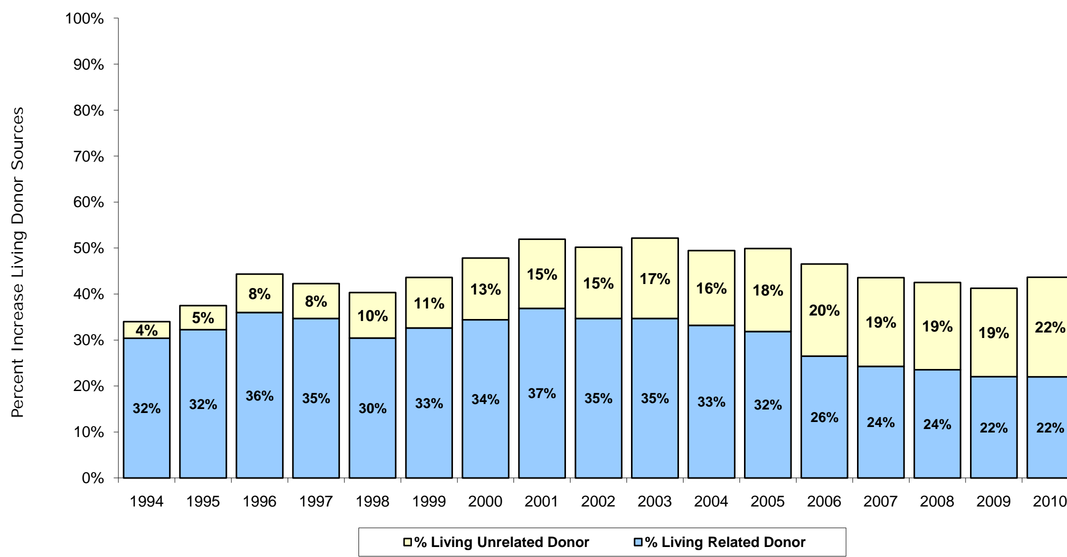
Of all dialysis patients served in 2010, 8.5% (2,063) dialyzed at home. Among self-care dialysis patients, 19% used home hemodialysis. This percentage has been increasing over the last 7 years. See dialysis prevalence data table.

Highest Volume of Renal Transplants in the Nation

Network 11 leads the nation in the number of transplants performed. In 2010, 1,487 kidney transplants were performed. This is over 50% above the average number of renal transplants conducted nationwide (976). We also lead the nation in renal transplant prevalence (18,739), which is nearly twice the national average (approximately 9,800). Of the transplant recipients, 83% (15,543) were residents of the five states Network 11 serves.

In Network 11 as well as nationally, the number of renal transplants in 2010 decreased from the number in 2009. Nationwide, transplants from living donors accounted for 35% of all renal transplants in 2010, a decrease of 1% over 2009. In Network 11, transplants from living donors accounted for 51% of all renal transplants, an increase of 10% over 2009. Finally, the trend in renal transplants from living unrelated donors from 1993 to the present represents a dramatic increase nationwide, with Network 11 leading the way. Figure 4 illustrates this trend.

Figure 4. Percent Increase in Living Donor Sources in Network 11, 1993–2010



Network 11 Staff

Administrative Team

Diane Carlson, RHIA, Executive Director, has served Network 11 for 31 years. She reports to the President and staffs the Executive Committee—the Network 11 Board of Directors. Diane is responsible for CMS contract management, personnel management, organization policies and procedures, program administration, and finance management.

Barbara Meier, Office and Finance Coordinator, has served Network 11 for 23 years. Barb coordinates finance management by preparing and filing all legally required tax reports, CMS cost reports, subcontracting reports and processing accounts payable including payroll. Barb also coordinates office operations by processing incoming information requests, new patient addresses corrections, and purchasing of all supplies and office equipment. With a background in health information and experience working with all Network 11 departments, she also supports the QI and Data Teams with special projects.

Anna Heininger, Communications Coordinator, has worked with Network 11 for 4 years. She is the assistant to the Executive Director. She performs community outreach duties by facilitating the distribution of Network communications and educational resources for new providers. Anna also organizes the production of Network 11 Reports and coordinates arrangements for Network meetings.

Quality Improvement Team

Jan Deane, RN, CNN, Director of Quality Improvement and Consumer Services, has worked with Network 11 for 17years. With 38 years of renal nursing experience, Jan staffs the Medical Review Committee, manages the QI program, oversees patient services, coordinates clinical technical assistance and focused review activities. She is the liaison between Network 11 and the State Survey Agencies.

Renae Nelson, MSW, Patient Services Coordinator, has served Network 11 for 5 years. Renae has 14 years of experience as a Renal Social Worker, as well as additional medical social work experience. She staffs the Consumer Committee, processes patient and facility concerns, and contributes to consumer–focused special projects.

Kristen Ward, MPH, QI Systems Specialist, has served Network 11 for 4 years. Kristen holds a Masters Degree in Biostatistics from the University of Minnesota. She collaborates with the QI team on projects including Fistula First, the Network 11 Composite Quality Report, unit–specific reports, first–year transplant outcomes, Elab Project, and QI workshops.

Chris Singer, MAN, RN, CNN, Quality Improvement Coordinator, has been with Network 11 for 7 years. With over 14 years of nephrology nursing experience, Chris is a clinical resource for Network 11 ESRD facilities. She coordinates QI projects such as Fistula First, analysis of facility–specific profiles, emergency preparedness, 5-Diamond Patient Safety Project, the Transplant Consortia, and QI workshops. Chris is also the Network 11 manages the Upper Midwest Fistula First Coalition.

Data Team

Cheryl Dickhausen, Health Data Specialist, has been with Network 11 for over 8 years. With a degree and background in social services and medical office work, she serves dialysis facilities in the Greater Michigan area in all aspects of registry maintenance, including forms processing, annual facility surveys, and other data reconciliation projects. Cheryl leads data clean–up initiatives and other special projects.

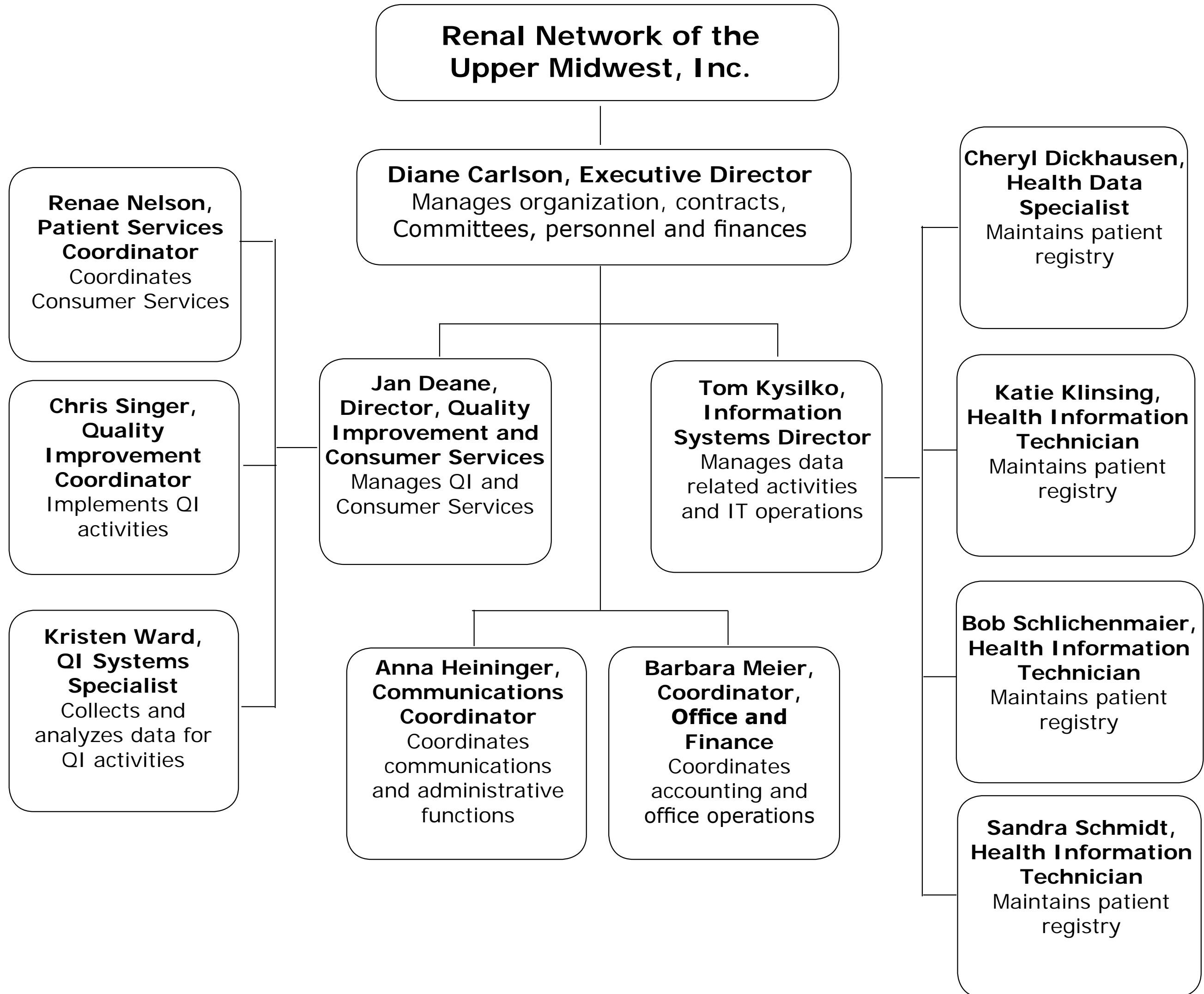
Katie Klinsing, Registered Health Information Technician, has been with Network 11 for 3 years. Katie holds a degree in Health Information Technology. She serves facilities in Wisconsin in all aspects of registry maintenance, including processing notifications and tracking QualityNet Identity Provisioning System (QIPS) accounts.

Tom Kysilko, Information Systems Director, has served Network 11 for 17 years. Tom manages data operations, administers the local area network and maintains the Network 11 Website. He is responsible for conducting data analysis, ensuring data integrity, coordinating Network 11 data functions with SIMS and CMS, obtaining and maintaining computer equipment, coordinating special Information Technology (IT) projects, providing technical support to VISION users, and assisting CMS with the implementation of CROWN Web within Network 11. Tom is the Network 11 point of contact for the Email system and for the security of information systems.

Sandra Schmidt, Registered Health Information Technician, has worked with Network 11 for 17 years. Sandy holds a degree in Health Information Technology. In addition to maintaining the patient registry for Minnesota, North Dakota, and South Dakota, Sandy is responsible for coordinating kidney transplant data. She also assists with developing data policies and procedures.

Bob Schlichenmaier, Health Information Technician, has been with Network 11 for 8 years. With a Health Information Technology degree and a Business Management degree, Bob serves facilities in the Detroit metropolitan area in all aspects of registry maintenance. Bob also provides Information Technology (IT) back–up support, assists with Website updates, and serves as the desktop publisher for quarterly data newsletters.

Renal Network 11
Staff Organizational Chart
2010



Network 11 Committees

Network 11 Council

Each Medicare-certified ESRD facility may appoint two voting members to Network 11's Council, with one of the two voting members being the Medical Director. Consumer Committee members are also voting members. Other renal organizations have non-voting memberships on the Council. The Council oversees Network 11's goals, objectives, and elections.

Council members elect representatives to the Executive and Medical Review Committees. Network 11 convenes its Annual Council meetings in the fall. Please see the Educational Resources section of this report for more information about the Annual Meeting.

Executive Committee

Function: The 13-member Executive Committee is Network 11's Board of Directors. This Committee directs the business and affairs of the organization by overseeing corporate affairs, personnel management, finance management, and contract business, as well as oversight of the nominations and election process.

Composition: Committee membership is well balanced and representative of the region served. The newly elected Executive Committee has five members from Michigan, two from Wisconsin, four from Minnesota, one from North Dakota, and one from South Dakota. The Committee has six Registered Nurses, five Nephrologists, and two Consumers.

Activities: During 2010, the Executive Committee met four times. Three meetings were by conference call, and one meeting was in-person. The Executive Committee activities in 2010 included the following.

1. Elected officers for the 2011-2012 term
2. Planned 2010 Annual Council Meeting
3. Monitored CMS Special Projects including the Elab Project
4. Assured that Network 11 meets CMS contract requirements with the following actions:
    - Monitor submission of contract deliverables quarterly
    - Review CMS annual site visit report
    - Approve Medical Review Committee Recommended Treatment Goals
    - Approve the Network 11 Quality Improvement Work Plan
5. Provided oversight and offered guidance on the Medical Review Committee activities
6. Provided oversight and offered guidance on the Consumer Committee activities
7. Kept apprised of national affairs including
    - CROWN Web implementation plans
    - The Quality Incentive Plan for ESRD Providers
    - The Proposed Payment System for ESRD Providers
    - Forum of ESRD Networks activities and special projects
8. Approved finance reports and quarterly received updates on financial audit and tax reports filed, as required.

Medical Review Committee

Function: The Medical Review Committee reviews the care of the ESRD patients in Network 11, oversees quality improvement activities, and performs functions as required by CMS. Each year, the MRC publishes recommended treatment goals and medical review criteria to guide facilities in developing their quality improvement programs. The goals and criteria are distributed every year to facilities and are posted on the Network 11 Website.

Composition: The 17-member Medical Review Committee is comprised of fifteen clinicians elected by the Network Council and two consumer members selected by the Consumer Committee. The membership consists of the following members.

- Eight nephrologists: six nephrologists, one pediatric nephrologist, and one transplant nephrologist
- Four nephrology registered nurses including one transplant coordinator
- One transplant/vascular access surgeon
- One nephrology social worker
- One nephrology dietitian
- Two consumers

Activities: The Medical Review Committee meets quarterly each year, twice in-person and twice by conference call. Meetings were convened on May 14, August 20, October 14, and December 17, 2010.

The Medical Review Committee activities for 2010 include the following.

- Directed implementation of the Fistula First Project and reviewed the progress of the Upper Midwest Fistula First Coalition.
- Made facility-specific determinations based on the Medical Review Recommended Treatment Guidelines using Elab Report results.
- Reviewed first–year outcomes for 21 transplant facilities.
- Reviewed and updated the recommended treatment goals.
- Developed and submitted to CMS a Quality Improvement Work Plan (QIWP) as required by the contract with CMS. The 2009-2010 QIWP consists of projects addressing increasing AV fistula prevalence rates, reducing missed dialysis treatments, improving tracking and reporting of immunizations, and developing comprehensive Quality Assessment and Performance Improvement Programs.
- Monitored patient concerns including involuntary discharges.
- Reviewed and made recommendations for two quality of care referrals.
- Reviewed and approved emergency preparedness materials.
- Reviewed and monitored the Consumer Committee's production of the My Life: My Choice pamphlet on modalities of care from the patient's perspective.
- Monitored the progress of the national Elab project and offered assistance.
- Reviewed immunization rates for influenza, pneumonia, hepatitis B, and H1N1.
- Launched the 5-Diamond Patient Safety Project and Transplant Consortia Webinars.

Consumer Committee

Function: The Consumer Committee is focused on developing and distributing educational information to promote the quality of care and quality of life for all Network 11 consumers. This Committee works closely with the Medical Review Committee when determining the scope and focus of a project.

Composition: Network 11's Consumer Committee is comprised of thirteen ESRD (dialysis and transplant) consumers. The members are elected based on geographic representation of the prevalence population. The Committee currently includes five members from Michigan, two members from Wisconsin, four members from Minnesota, and one member each from North and South Dakota. Important Consumer Committee activities in 2010 include the following.

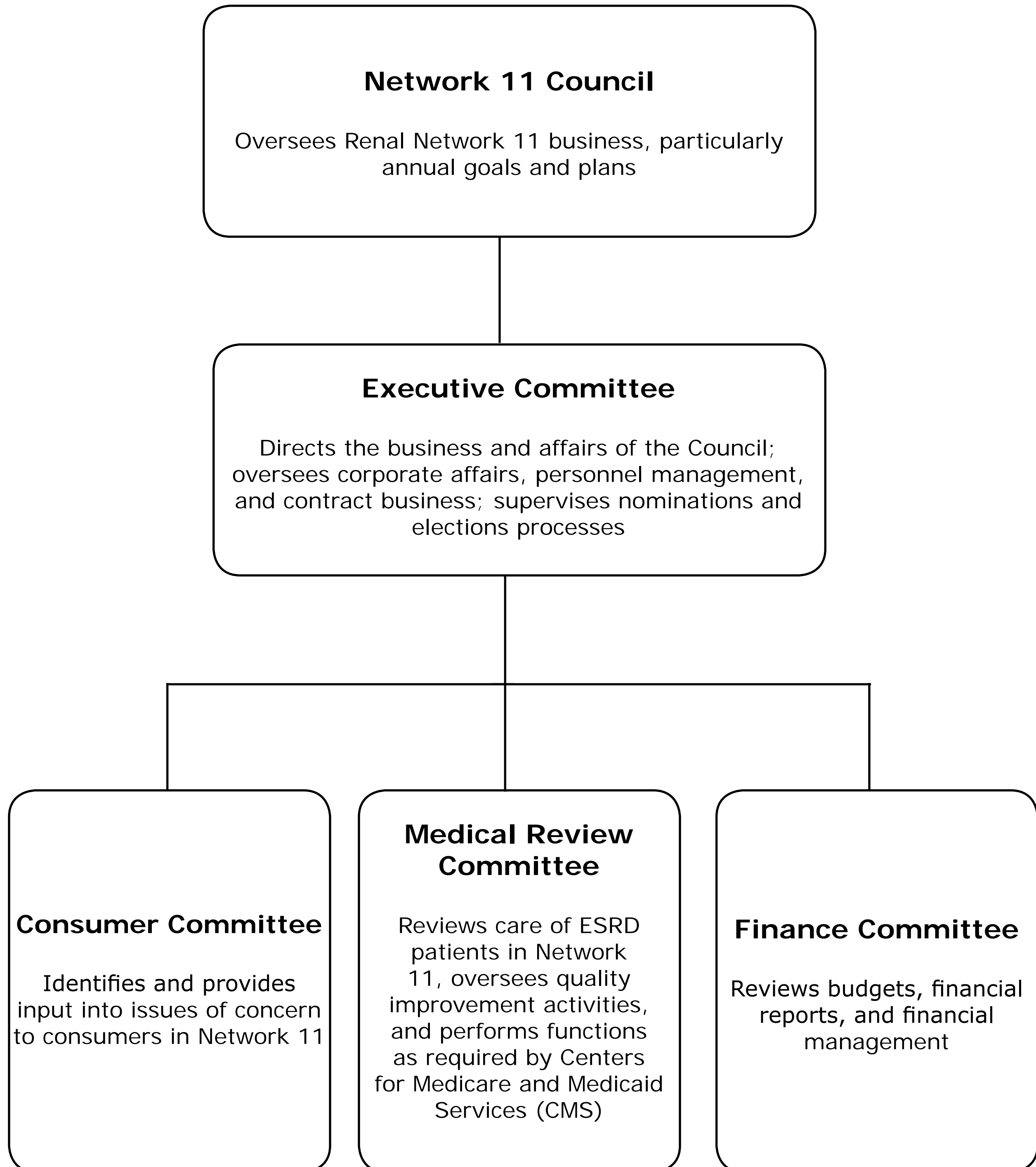
Activities: In 2010, the Consumer Committee conducted monthly conference calls except for the months of August and December. Accomplishments during 2010 included the following.

- The Network 11 Consumer Committee saw a need for a resource for patients trying to decide which modality is better for them and suits their lifestyle. The Consumer Committee developed a booklet entitled, "My Life, My Choice", that is unique in that it not only explains ESRD treatment options, but also shares the experiences from people with kidney disease on why they chose their treatment modality. Copies were mailed to all Network 11 dialysis units and transplant facilities.
- Published two issues of Common Concerns. One issue focused on transplant. The other issue focused on infection control. Both issues were mailed to over 43,000 ESRD patients homes in Network 11. Copies are made available to facilities both electronically and on the Network 11 website.
- Provided ESRD consumer input through representation on the Executive Committee and the Medical Review Committee as well as the Upper Midwest Fistula First Coalition.
- Elected members to fill vacancies on the Consumer Committee.

Finance Committee

The full Executive Committee reviews financial reports and financial management matters, with input from the Secretary-Treasurer. Please see organizational chart illustrating all Network 11 Committees.

Renal Network 11 Committee Organizational Chart 2010



Internal Quality Program

Network 11 is a quality improvement organization. Our quality improvement efforts are not only focused outward, but inward as well. Network 11 uses the Institute for Healthcare Improvement Model for Improvement to assess the quality of work. This model uses three questions to assist in rapid cycle improvement.

- What are we trying to accomplish?
- What changes can we make that will result in an improvement?
- How will we know that an improvement was made?

During 2010, Network 11 conducted improvement projects for all contract areas. Following are some of the project topics. Please see other sections of this report for more specific information about each topic.

Task 1 – Quality Improvement

- Maintain 100% of eligible HD facilities submitting vascular access data
- Achieve 0.75% improvement in AVF rate each calendar quarter
- Contact 75% of facilities monthly, who are not on pace to meet their facility-specific AVF goal

Task 2 – Community Information and Resources

- Give providers regular updates on information/resources posted to Network 11 Website
- Send new Provider Packets to all newly opened ESRD facilities in NW11
- Evacuate all NW11 staff present at the time of a disaster drill in the NW11 office
- Assure that emergency equipment in office is functioning and ready for use
- Reconcile PAR and SIMS contacts for patients involuntarily discharged
- Request 100% of patient involuntary discharge letters

Task 3 – Administration

- Orient new Committee members
- Keep staff apprised of events, deliverables, and activities
- Conduct quarterly calls with the State Survey Agencies
- Complete and submit all CMS deliverables on time
- Complete quarterly report accurately and on time
- Maintain an accurate directory of all Network 11 vendor contacts

Task 4 – Information Management

- Keep ratio of notifications accepted to 2728s transmitted <.05
- Transmit 90% of forms within 15 working days
- Report to CMS on facility progress using CROWN Web
- Obtain delinquent renal transplant registration and follow-up information from UNOS
- Respond to selected inquiries from organizations on a CMS provided/approved list of Medicare Advantage organizations

Business Continuity Plan

Network 11 Emergency Preparedness and Business Continuity Plan

This comprehensive document offers guidance on Network 11's contractual requirements, identifies staff leads, expectations of staff, emergency calling information, critical records back-up. It provides procedures for emergency situations that may arise in the work setting. Though extensive, the document is user-friendly, with the goal of keeping each topic to one page.

Network 11 maintains an extensive list of vendors that may need to be contacted in the event of a disaster. Vendor groups include local emergency management contacts, financial institutions, insurance companies, and service providers such as accountants and attorneys. Having this information at hand will facilitate re-establishing operations in the event of a disaster. The vendor information is reviewed and updated each year in January and July.

Network 11 Disaster Planning

Network 11's Business Continuity Plan (BCP) resulted from intensive research conducted in 2006. The BCP continues as a work in progress. In 2010, updates included the following.

- Updated the Network 11 Business Continuity Plan.
- Updated the Kidney Community Emergency Response (KCER) Emergency Key Contacts list.
- Updated the comprehensive Vendor Spreadsheet.
- Updated the Network 11 Emergency Contact list.
- Maintained two National Oceanic and Atmospheric Administration (NOAA) Weather Radios for the office.
- Maintained walkie-talkies in the office so that staff could continue to communicate if separated.
- Added flowcharts for Network 11's response in the event of a disaster.

Safe-Guarding Network 11 Staff

A single staff member has been designated to monitor severe weather using a NOAA Weather radio. This person notifies staff of local severe weather warnings via e-mail. In addition to weather alerts, the NOAA system broadcasts information for all types of hazards—including environmental mishaps (such as chemical releases). A back-up weather watcher also was named to cover when the primary monitor is not in the office.

The Network 11 Disaster Coordinating Committee also prepared materials to educate Network 11 staff on how to respond to emergencies that may occur in the Network 11 office. Two emergency drills were conducted in 2010 to evaluate both the education offered and the process for emergency response. The drills were conducted in areas of fire response and severe weather response. Ongoing education efforts for staff are being planned for 2011.

Disaster Preparedness Collaboration Activities

Network 11 continues to partner with local, regional, and national agencies to help both Network 11 and providers within the region to participate in activities that will assist ESRD patients and providers to be prepared in the event of an emergency or disaster.

- Network 11 participates with the Kidney Community Emergency Response (KCER) coalition to collaborate with providers, local disaster agencies, and national agencies to enhance Network 11's readiness for disasters in the Upper Midwest region.
- Network 11's Quality Improvement Coordinator participates in the Facility Operations Workgroup.
- Network 11 has also developed partnerships with local agencies to ensure patients with ESRD are a high-priority population during a local or regional disaster.
- Network 11 has corresponded with all five state-level disaster coordinating centers to develop strategies that will bring additional focus to patients with ESRD during a disaster.
- Network 11 partners with the State Survey Agencies to coordinate efforts for locating and placing ESRD patients in the event of a disaster.
- Network 11 continues to partner with its providers and community to provide tools and resources that will help them prepare for a disaster.
- Continued to include Emergency Preparedness materials in new provider packet, which is sent to all new providers in Network 11.
- Sent an email blast to all facilities reminding them of resources in emergency preparedness available on Network 11 Website.
- For more information regarding Network 11 Emergency Preparedness activities with dialysis facilities, please see Network Activities section.
- All new dialysis providers were given the Facility Toolkit to assist them to develop their facility emergency preparedness plan.

Mutual Aid Agreement

Network 8 and Network 11 have established a fully executed agreement to serve as providers of mutual aid to one another in the event of disaster.

Network 8 Inc.

CMS National Goals and Network Activities

Network 11 Goals and Objectives

MRC Treatment Goals and Review Criteria

Quality of Care and Quality of Life

Improving Data

Partnerships and Cooperative Activities

Patient Grievances / Consumer Services

Goals and Objectives of Renal Network 11

Network 11 Mission Statement

The purpose of the Renal Network of the Upper Midwest (Network 11) is to assess and improve the quality of care provided to individuals with end stage renal disease.

Network 11 Goals and Objectives	Evidence that Goals are Met
Goal A Maintain a Network organization to serve the ESRD community in the Upper Midwest. 1. Maintain Network Council memberships. 2. Elect and coordinate the activities of the Executive, Medical Review, and Finance Committees. 3. Organize and conduct an Annual Council meeting. 4. Maintain a Network 11 provider directory. 5. Serve as a clearinghouse for ESRD information. 6. Participate in the Forum of ESRD Networks. 7. Manage organizational affairs including personnel, finances, office management, Council affairs, and relations with CMS. 8. Maintain publications and memberships in related agencies. 9. Update bylaws as needed.	Goal A Maintained a Network organization to serve the ESRD community in the Upper Midwest 1. Have 900 Council members. 2. Elected 2011-2012 members to the Executive and Medical Review Committees. Each Committee met 4 times during the year. 3. Organized and convened an Annual Council meeting on 10/15/2009 in Saint Paul, MN. 4. Updated and posted a provider directory to the Website quarterly. 5. Provided educational and informational mailings to dialysis facilities and received 30,000 views of Website per quarter. 6. Served as active member of the Forum's Board of Directors. 7. Offered quarterly progress reports to CMS and the Executive Committee on finances and organizational business. 8. Maintained subscriptions to NRAA, ANNA, and relevant periodicals. 9. Followed current bylaws.
Goal B Promote home dialysis and transplantation, when medically indicated. 1. Monitor rates of home dialysis and transplantation in Network 11. 2. Collaborate with other organizations to promote these modalities. 3. Provide education regarding home dialysis and transplantation.	Goal B Promoted home dialysis and transplantation 1. Reported home dialysis and transplantation rates in Network 11's Annual Report. 2. Joined Workplace Partners for Life, an organ donation organization. 3. Issues of the patient newsletter Common Concerns addressed Peritoneal Dialysis and Kidney Transplant. A patient options booklet was developed to educate patients on each type of modality.

Network 11 Goals and Objectives	Evidence that Goals are Met
Goal C Promote vocational rehabilitation 1. Tabulate employment and vocational rehabilitation data.	Goal C Promoted vocational rehabilitation 1. Reported vocational rehabilitation data in the Annual Report.
Goal D Evaluate patient care using criteria and standards relating to the quality and appropriateness of care 1. Analyze and report facility-specific first-year patient and graft survival data for transplant recipients. 2. Analyze and report facility-specific lab data reports for dialysis facilities. 3. Perform quality improvement projects as directed by CMS and the Medical Review Committee.	Goal D Evaluated quality of care. 1. Analyzed and reported first-year transplant outcomes by transplant center. 2. Generated facility-specific Elab reports. Analyzed Elab data and distributed facility-specific Elab reports. Commended facilities with best practices and offered technical assistance as needed. 3. Based on analysis and regional variation in outcomes, conducted quality improvement projects on: • Increasing AVF prevalence, • Decreasing missed treatments, • Improving reporting of immunization rates, • Developing a comprehensive quality assessment and performance improvement program regarding vascular access.
Goal E Conduct quality improvement activities. 1. Monitor and report providers' compliance with Network 11 goals and objectives. 2. Conduct on-site visits as necessary. 3. Collaborate and coordinate with State Survey Agencies.	Goal E Conducted quality improvement activities. 1. Offered technical assistance in preparing QI plans with facilities identified through the Elab project. Offered technical assistance in preparing QI plans to 180 facilities based on Fistula First data. 2. Conducted 16 on-site and 6 off-site visits for selected facilities to identify strategies to improve AVF prevalence. 3. Conducted quarterly calls with State Survey Agencies; addressed new Conditions for Coverage; and consulted with State Surveyors with quality of care concerns prior to recertification visits.

Network 11 Goals and Objectives	Evidence that Goals are Met
Goal F **Assist patient access to care** 1. Identify providers to patients seeking ESRD services 2. Promote equitable access for ESRD services	**Goal F** 1. Referred patients seeking ESRD services to Dialysis Facility Compare and other resources. 2. Minimized the overall involuntary patient discharge rate to 0.78 discharges per 1000 dialysis patients, the lowest rate in Network 11's recorded history. ▪ Reduced the number of involuntarily discharged patients for noncompliance to 2 in 2010, also the lowest number in Network 11's recorded history. ▪ Averted involuntary discharges in 144/163 (88%) of contacts regarding discharge, noncompliance, disruptive, and abusive situations.
Goal G Implement procedures to resolve patient grievances. 1. Address patient concerns related to quality of care, access to ESRD services, and rehabilitation. 2. Respond to patient grievances according to CMS Patient Grievance Policies.	Goal G Responded to patient concerns. 1. Processed 414 concerns from patients, facilities, and facility personnel. ▪ Recommended use of the Decreasing Patient Provider Conflict materials for specific concerns resulting from conflict situations. ▪ Provided Patient Rights & Responsibilities posters for all facilities. Collaborated with the State Survey Agency to verify that these posters are displayed in patient waiting areas. 2. Resolved patient complaints before they became grievances, so no grievances files in 2010.
Goal H Facilitate patient participation. 1. Elect and coordinate activities of the Consumer Committee. 2. Publish the patient newsletter, Common Concerns. 3. Prepare and mail orientation information to new ESRD patients.	Goal H Facilitated patient participation. 1. Elected several new members to the Consumer Committee, which met 10 times in 2010. 2. Published and distributed semiannual editions of Common Concerns to about 43,000 patients. 3. Assisted mailing of new patient packets to 7,198 patients in 2010.

Network 11 Goals and Objectives	Evidence that Goals are Met
Goal I Maintain, safeguard, and use a patient registry to report ESRD Program trends and trends in morbidity and mortality. 1. Respond to requests for data and information, as appropriate. 2. Obtain, validate process, submit, correct, and file CMS forms. 3. Work with CMS and UNOS on transplant and transplant follow-up data. 4. Process monthly rosters for dialysis patients and quarterly lists of new transplant recipients. 5. Prepare and transmit data forms to the national registry. 6. Monitor data compliance. 7. Process facility surveys. 8. Upgrade hardware and software as needed. 9. Back-up data and preserve confidentiality. 10. Participate in the Standardized Information Management System (SIMS).	Goal I Maintained, safeguarded, and used the ESRD patient registry. 1. Responded to 3,500 data and information requests in 2010. 2. Processed the following in 2010. ▪ 7,813 Medical Evidence Forms ▪ 5,613 Death Forms ▪ 99,526 modifications to SIMS ▪ 5,920 provider directory changes ▪ 12,441 notifications 3. Collected transplant and transplant follow-up data from 21 transplant centers in NW 11. 4. Processed 4,973 Patient Activity Reports. 5. Data were processed, corrected, entered, and submitted within the timeframe specified by CMS. 6. Monitored data compliance in all NW 11 facilities and employed a quality improvement process for those facilities not achieving 90% compliance rates. 7. Balanced and reconciled 445 Year 2010 Facility Surveys. 8. Upgraded hardware as required by CMS. 9. Backed up data nightly and stored tapes off-site. All NW 11 staff and Committee members sign confidentiality statements and those are updated periodically. 10. Actively participated in SIMS and the conversion to CROWNWeb.
Goal J Contribute to national ESRD program priorities. 1. Administer the contracts that Network 11 has with CMS and others 2. Prepare an Annual Report for CMS and other interested parties. 3. Participate in the Clinical Performance Measures Project and other national studies	Goal J Contributed to the national ESRD program priorities. 1. Assured that CMS contract deliverables were met through oversight from Network 11 staff and Executive Committee. 2. Prepared and submitted to CMS a 2008 Annual Report outlining the activities of Network 11. This report was posted to the Network 11 Website for use by the renal community and other interested parties. 3. Received a contract from CMS to collect, analyze, and generate facility-specific reports as part of the national Elab project.

Network 11 Goals and Objectives	Evidence that Goals are Met
Goal K Continue to conservatively manage finances. 1. Review and update financial policies. 2. Follow financial management guidelines.	Goal K Managed finances conservatively. 1. Followed financial policies. 2. Conducted independent financial audit and reported results to the Executive Committee. 3. Continuously assessed and implemented ways to save money such as: ▪ Renegotiated professional liability insurance. ▪ Used email and Website rather than mail. ▪ Took advantage of volume discount printing whenever possible.
Goal L Assure that outcomes are comparable to expected outcomes as defined by currently accepted standards of care. 1. Set annual recommended treatment guidelines based on currently accepted standards, i.e., the KDOQI guidelines or CMS Clinical Performance Measures. 2. Provide facility-specific data that is compared with state and Network data.	Goal L Assured that outcomes were comparable to expected outcomes as defined by currently accepted standards of care. 1. Updated Medical Review Committee Recommended Treatment Goals and Review Criteria for dialysis facilities. These guidelines were updated by the MRC, approved by the Executive Committee, distributed to dialysis facilities and posted to Network 11 Website. 2. Elab reports, Fistula First reports, immunization reports, and first-year transplant outcome reports are all facility-specific reports which compare the facility with other facilities in the state, Network, and nation (as data are available).

MRC Recommended Treatment Goals

Approved by Network 11 Medical Review Committee December 2011

Each year, the Medical Review Committee (MRC) reviews its recommended treatment guidelines and makes revisions based on changes in clinical practice guidelines. This process has been completed, and enclosed in this mailing are the newly revised guidelines for 2011. The MRC and Executive Committee approved these guidelines in December 2010. The following are changes to the guidelines for this year and the rationale for the changes.

- Anemia Management. In an effort to align with the CMS Prospective Payment System and the Quality Incentive program, the guidelines for anemia management have been changed. The new guidelines recommend that facilities strive for target hemoglobin of 10-12 gm/dL. In addition, the less than 10 and greater than 13 thresholds have been lowered to < 8% of patients with hemoglobin concentration of < 10 gm/dL and < 8% of patients with hemoglobin ≥ 13 gm/dL (see guidelines page 1). These new thresholds reflect the Network averages for 4th quarter 2009. Best practice guidelines parameters remain the same with the exception of the target range, which is changed from 11-12 gm/dL to 10-12 gm/dL.

- Hemodialysis Adequacy. For 4th quarter 2009 data, the Network 11 median facility results for URR and Kt/V results continued to increase. Because of this, the MRC has increased the MRC Recommended Guideline and the Best Practice Guideline for hemodialysis adequacy to 90% and 95% respectively (see Guidelines, page 1). In addition, the recommendation for home hemodialysis patients on frequent dialysis (≥ 4 times per week) is increased to 85%.

These treatment guidelines are to assist your facility as you develop and update your Quality Assessment and Performance Improvement program and to keep you informed regarding the MRC facility-specific review process.

Recommended	Best Practice
Facilities should target hemoglobin levels between 10-12 gm/dL. A normal distribution of Hgb levels centered around this target will include: • < 8% of patients with mean Hgb < 10 gm/dL, AND • < 8% of patients with mean Hgb ³ 13 gm/dL.	• Meets the Recommended Treatment Goals AND • A percent of patients having hemoglobin within the target range of 10-12 gm/dL that falls in the highest 10% of facilities in Network 11.

- Facilities will monitor and evaluate iron status through regular measurement of transferrin saturation (TSAT) and Ferritin. Facilities will also maintain and follow a policy for administration of supplemental iron based on K/DOQI guidelines.

Recommended	Best Practice
90% of HD patients on three times per week dialysis will have a mean URR of at least ³ 65% or delivered Kt/V of ³ 1.2 ≥ 85% of patients on frequent hemodialysis (≥ 4 times per week) will have a mean weekly Kt/V of ≥ 2.0.	> 95% of HD patients on three times per week dialysis will have a mean URR of at least ³ 65% or delivered Kt/V of ³ 1.2

- Blood sampling for hemodialysis adequacy studies should be done by either the "slow flow" or "stop pump" technique to assure consistency in adequacy results (see K/DOQI Hemodialysis Adequacy Guideline 8).
- Kt/V should be measured in accordance with the recommendations in K/DOQI Guideline #2, that is, formal urea kinetic modeling (single pool, variable volume model) or the natural logarithm model.

Recommended	Best Practice
80% of PD patients will have a weekly Kt/V of 1.7	> 85% of PD patients will have a weekly Kt/V of 1.7

- 100% of PD patients will have adequacy of dialysis measured every four months. The initial measurement should be performed within 2-3 months of starting PD. Additional measurements should be performed at such time a change in clinical condition appears.
- Prescribed dose of PD should be altered as needed to maximize clearance, especially if the patient appears to have uremic signs and symptoms (PD Adequacy Guideline 2.1, 2006).

Recommended	Best Practice
³ 80% of dialysis patients (HD and PD) will have mean serum albumin ³ the lower limit of normal (LLN), and no more than 10% of patients will have mean serum albumin < 0.9 LLN	> 85% of dialysis patients (HD and PD) will have serum albumin ³ the lower limit of normal (LLN), and no more than 10% of patients will have mean serum albumin < 0.9 LLN

- Serum albumin results are more dependent on lab methodology than are other indicators. The above goal is based on the lab's reported lower limit of normal established for a normal, healthy population. Reference ranges based on other populations (e.g., dialysis patients, hospitalized patients) are not comparable.

Recommended	Best Practice
³ 65% of dialysis patients (HD and PD) will have a mean serum phosphorus of 3.5-5.5 mg/dL < 10% of patients will have mean serum phosphorus of > 8 mg/dL	> 70% of dialysis patients (HD and PD) will have a mean serum phosphorus of 3.5-5.5 mg/dL < 5% of patients will have mean serum phosphorus of > 8 mg/dL
³ 80% of dialysis patients (HD and PD) will have a mean corrected serum calcium concentration of £ 10.2 mg/dL.	> 85% of dialysis patients (HD and PD) will have a mean corrected serum calcium concentration of £ 10.2 mg/dL. > 75% of dialysis patients (HD and PD) will have a mean corrected serum calcium concentration of £ 9.5 mg/dL.
≥80% of patients will have PTH monitored at least every 3 months	

- At the current time, the MRC cannot recommend specific review parameters for PTH due to variability of available PTH assays and paucity of bone biopsy correlations with these PTH assays. See Souberbielle JC, Boutten A, et al. Inter-method variability in PTH measurement: implication for the care of CKD patients. Kidney Int 2006:70(2):345-350.
- The MRC strongly recommends that each facility should decide upon a desired range for PTH for the dialysis patients receiving care in that facility. For good patient care, it is important to maintain PTH within a range that avoids low turnover bone disease (low PTH) and hyperparathyroidism (high PTH). The desired range for each facility will depend upon the assay that is being used and its comparison to the intact PTH assay that was used for the original K/DOQI Guidelines (see reference above).
- The MRC does recommend that facilities monitor PTH regularly and further recommends that facilities work with their lab to monitor which assay is being used, the reference range, and ask to be notified when assays or reference ranges are changed.
- The MRC anticipates that a PTH Guideline will be re-implemented as more evidence becomes available regarding the bone biopsy and clinical correlations with the currently available PTH assays.

Recommended	Best Practice
Facility AVF rate will achieve an annual increase that equals at least the specific goal set for that facility*.	³ 65% of prevalent patients dialyze with an AV fistula
£ 10% of prevalent patients are dialyzing with a catheter as sole access > 90 days	£ 5% of prevalent patients are dialyzing with a catheter as sole access > 90 days

* The facility goal is based on the following formula:

(66% [CMS program goal]) – (facility baseline percent [AVF rate in Q4]) x 20%

This formula applies to facilities whose 4th quarter AVF rate is less than 65%. The improvement goal set for each facility with an AVF rate less than 65% will be at least 1% or greater based on the formula calculation.

- Dialysis facilities should have a protocol for evaluating patients with catheter as sole access for placement of an AV fistula.
- The patient care team should regularly review all patients who refuse to have a fistula placed and encourage them to consider a fistula.
- Facilities should track vascular access as part of their regular CQI process.
- Stenosis monitoring should be performed based on the guidelines established by K/DOQI (Vascular Access Guidelines 10, 11, and 12).

Recommended	Best Practice
³ 90% of patients will receive immunization for influenza ³ 80% of patients will receive immunization for pneumonia ³ 80% of patients without natural immunity will receive immunization for hepatitis B	³ 95% of patients will receive immunization for influenza ³ 85% of patients will receive immunization for pneumonia ³ 90% of patients without natural immunity will receive immunization for hepatitis B

- Frequency of immunization for each specific disease should be based on recommendations from the Centers for Disease Control and Prevention.
- Immunization records should be reviewed and updated on an annual basis as part of the long-tem care planning process.
- Self-reported immunization information from patients is acceptable. Facilities should maintain a record of the month and year of immunization.

Recommended	Best Practice
³ 80% of patients will have documentation that advance care planning discussions were conducted within 6 months of initiating dialysis	³ 85% of patients will have documentation that advance care planning discussions were conducted within 3 months of initiating dialysis

- Documentation should reflect patient input into the discussion.
- Advance care planning issues should be reviewed on an annual basis as part of the long-term care planning process.
- Documentation may consist of notations on the long-term care plan or in the progress notes.

Recommended	Best Practices
³ 85% of patients will be assessed by the nephrologist for transplant candidacy or referral within 6 months of initiating dialysis as demonstrated by documentation in the medical record	³ 95% of patients will be assessed by the nephrologist for transplant candidacy or referral within 3 months of initiating dialysis as evidenced by documentation in the medical record

Network 11 Review Process

General Information

The Medical Review Committee (MRC) reviews all facilities on a regular basis with respect to the clinical parameters described in the Recommended Treatment Goals. Data reported from the Elab Project and the Fistula First Project are used for this review process. Lab values used are the average of the first monthly value for each of three months (October, November, and December). The following guidelines for review of facilities are distributed to assure a fair and consistent process.

Intervention Options By Network 11

Based on the clinical parameters, the MRC has several options for intervention in order to improve facility results. These include:

Option 1: Letter commending facility for its "Best Practice Performance"

Option 2: Letter commending facility for meeting treatment goals

Option 3: Letter indicating discrepancies, with a six-month outcome follow-up

Option 4: Letter requesting a corrective plan with monthly or quarterly outcome follow-up

Option 5: On-site review

Option 6: Recommendation for sanction or alternative sanction

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Suggested Guidelines For Choosing Intervention Options 1-5

When reviewing facilities, primary and secondary review criteria can be assessed. Primary review criteria will include anemia, dialysis adequacy, and vascular access. The secondary review criteria will include nutrition and renal osteodystrophy management. Facilities can be compared based on the percent of patients meeting the target goals and the medians of these criteria for all centers. Individual facilities are placed into quartiles. The first or lowest quartile includes facilities in the 25th percentile. Targeting facilities in the 1st quartile for improvement seems a reasonable place to put the Network's major effort. However, if the first quartile result is very close to the Network goal, then the point at which the Network would target the facility would be dropped to a lower percentile. For each MRC facility review period, the quartile result for each clinical parameter will be assessed and the percentile adjusted with respect to the Network goal.

Primary Review Criteria

- **ANEMIA:** Percent of patients with Hgb ≤ 10 gm/dL fall within the lowest quartile of Network 11 facilities OR percent of patients with Hgb ≥ 13 gm/dL fall within the lowest quartile of Network 11 facilities.
- **ADEQUACY: Hemodialysis**: Percent of patients with URR ≥ 65% or delivered single pool Kt/V ≥ 1.2 within the lowest quartile or at a lower percentile as determined by the overall results with respect to the recommended treatment goal.
- **ADEQUACY: Peritoneal Dialysis:** Percent of patients with weekly Kt/V ≥ 1.7 within the first quartile or at a lower percentile as determined by the overall results with respect to the recommended treatment goal.
- **VASCULAR ACCESS:**
    - Percent of prevalent patients being dialyzed via a catheter as their sole access > 90 days falling within the lowest quartile, OR
    - Percent of AVF rate improvement falling within the lowest quartile.

Secondary Review Criteria

- **NUTRITION:** Percent of patients with serum albumin levels ≥ LLN within the first quartile or at a lower percentile as determined by the overall results with respect to the recommended treatment goal.

- **BONE AND MINERAL METABOLISM:** Either of the two following criteria present.
    - P: Percent of patients with P ≤ 5.5 mg/dL within the 1st quartile or at a lower percentile as determined by the overall results with respect to the recommended treatment goal.
    - Ca: Percent of patients with Ca ≤ 10.2 mg/dL within the 1st quartile or at a lower percentile as determined by the overall results with respect to the recommended treatment goal.

Based on these criteria, the intervention options 1-5 can be determined as suggested in the following table.

Intervention Option	Review Criteria
Option 1: Best Practice	* < 10% of patients with Hgb < 10gm/dL, AND < 10% of patients with Hgb ≥ 13gm/dL AND within top 10% of facilities for patients within the target range of 11-12 gm/dL. * > 85% patients with URR≥ 65 % * > 85% patients with Alb ≥ LLN * ≥ 65% prevalent patients with native fistula AND ≤ 5% patients dialyzing with catheter as sole access > 90 days * Calcium and phosphorus both meet best practice goals
Option 2: Letter of commendation	All of the MRC recommended treatment goals are achieved
Option 3: Letter suggesting improvement	1 or 2 of the secondary review criteria met
Option 4: Letter/Corrective plan	One primary review criterion met and one secondary review criterion met
Option 5: On-site visit	2 of 3 primary review criteria met or one primary review criterion plus 2 secondary review criteria met

For each review period, the overall results for the clinical parameters will be analyzed and the review criteria determined based on the lowest quartile (25th percentile) or a lower percentile if the lowest quartile result is very close to the recommended treatment goal. These criteria will be made available to the reviewers to expedite the review process.

Suggested Guidelines for Choosing Option 6

If a pattern of poor outcomes has not improved despite intensive monitoring, a special review team will be appointed. The review team will submit documentation for recommendation of sanctions or alternative sanctions to the full MRC at a regular or specially called meeting. If the MRC votes to recommend a sanction or alternative sanction, this recommendation with supporting documentation must be submitted to the full Executive Committee for their approval. If the Executive Committee also votes to recommend a sanction or alternative sanction, the Network 11 staff will work with the State Survey Agency, the Centers for Medicare and Medicaid Services, and other parties as needed to submit this recommendation.

Quality of Care/Quality of Life

Fistula First Project

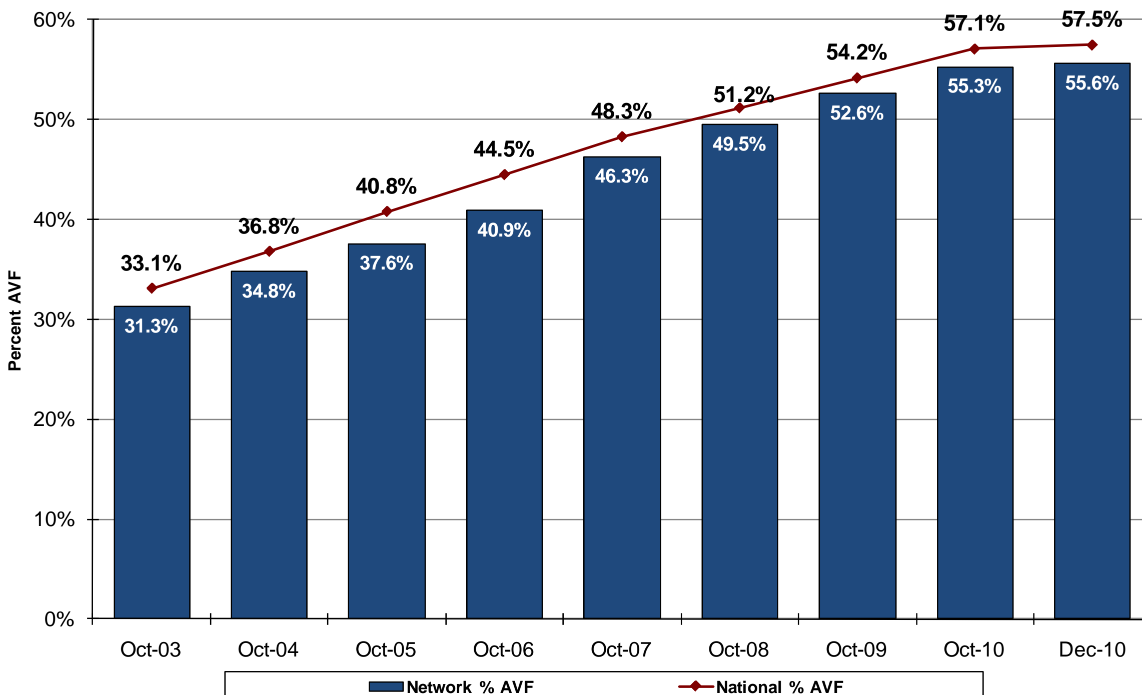
Background

Fistula First, now called the Fistula First Breakthrough Initiative, or FFBI, was launched in October 2003 to increase the AVF rate in the hemodialysis population.

- Nationally, as of December 2010, the percentage of patients dialyzing with an AV fistula has risen to 57.9%, an improvement of nearly 25% since the start of the Fistula First initiativ
- Network 11 has improved the use of AVF by over 24% since the start of Fistula First, achieving an AV fistula rate of 55.6% as of December 2010.
- The CMS goal for AV fistula prevalence in Network 11 included a 2.5% annual improvement in AV fistulas by March 2011. We are proud to report that met and exceeded this goal. Network 11 has achieved an annual improvement in AV fistula rates of 2.3% in 2010.

Vascular access is one of the most important issues facing chronic kidney disease patients, surgeons, nephrologists, and the nephrology team. The Kidney Disease Outcomes Quality Initiative (KDOQI) 2006 Vascular Access guidelines recommend that ≥ 65% of prevalent patients dialyze with an arteriovenous fistula (AVF). Also in 2006, CMS increased the national goal from 40% to 66% of patients using an AVF for hemodialysis.

Figure 1. Comparison of Network 11 and National AVF Prevalence Rates, 2003-2010



Why Fistula First?

Network 11 joined the Centers for Medicare & Medicaid Services (CMS), the Forum of ESRD Networks, and the renal community in the effort to increase the AVF rate in the hemodialysis population. A package of eleven change concepts was developed initially, and two additional change concepts were added in 2009. These change concepts have been used by ESRD Networks to develop and implement strategies for improving AVF rates. Network 11 is committed to assisting dialysis facilities to achieve improvement in AVF rates to at least the KDOQI guidelines. Figure 1 shows Network 11's progress since the start of the Fistula First project in October 2003.

What are the objectives?

The initial goal of the Network 11 Fistula First initiative was to increase the AVF rate among the prevalent hemodialysis patients from the rate of 31% (2002, CDC data) to at least 35.3% by June 2006. Since that time, CMS has updated the Network 11 goal to achieve up to a 4% annual improvement in AVF prevalence to be met by March of each year. To achieve these goals, the Network 11 Medical Review Committee (MRC) established the following objectives.

1. Create and build awareness of the Fistula First project by communicating with dialysis facility personnel, medical directors, surgeons and patients.
2. Identify best-practice facilities and share their experiences and successful strategies with other Network 11 dialysis facilities.
3. Build a data collection and reporting system to support Fistula First activities.
4. Identify and share resources within Network 11 dialysis facilities, especially for those that have low fistula rates.

How will Network 11 achieve these goals?

Fistula First Guidance

Network 11's Medical Review Committee has guided Network 11 to initiate activities to positively impact AVF rates. A multi-tiered strategy engaging the patient, dialysis facility, nephrologist, and vascular access surgeon was developed and enacted.

1. **Patient Strategies**

   Throughout the Fistula First initiative, Network 11 developed educational resources for dialysis facilities to enhance patient education regarding the Fistula First initiative.

These materials included the video Your Access To Success, as well as educational brochures, posters, and newsletters. Network 11 also developed two special editions of the Network 11 patient newsletter, Common Concerns, focused on educating patients when making decisions on vascular access. In 2010, Network 11 continued to distribute these resources to providers to encourage continued patient education in vascular access outcomes. In addition, the Upper Midwest Fistula First Coalition developed a number of resources that focused on education resources, including the WebEx presentation, Overcoming Resistance, a resource for dialysis facility staff that provides education about overcoming resistance in the dialysis facility. An Access Assessment poster was also developed to educate both patients and facility staff how to effectively assess vascular access before initiating dialysis treatment. Please see coalition section for more details.

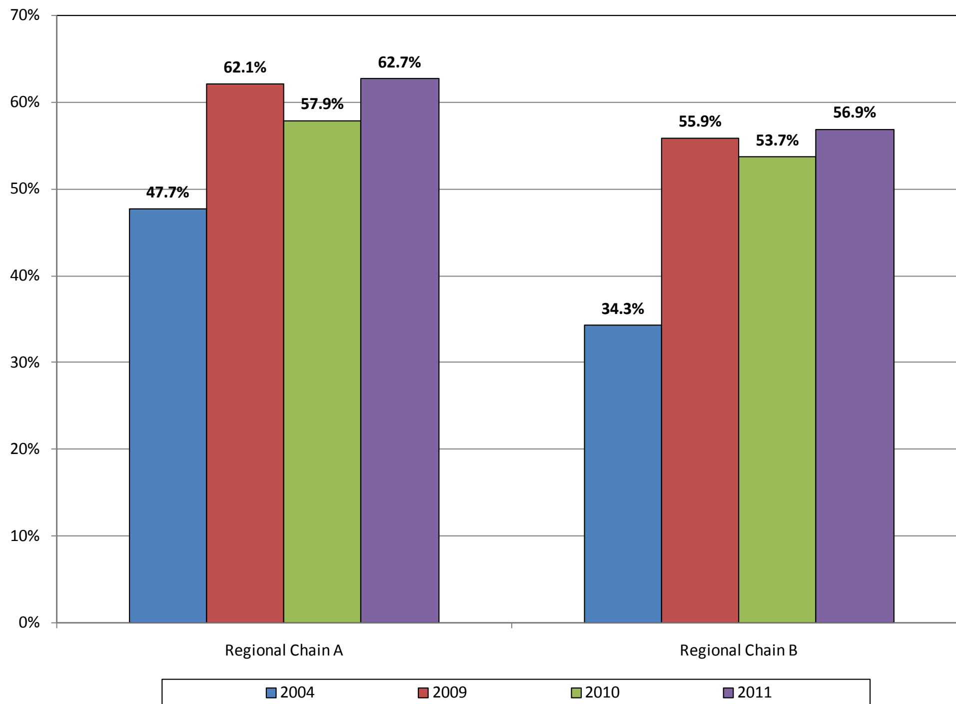
2. **Provider Strategies**

   Network 11 has worked with dialysis providers to provide patient and staff education that will assist them in improving the AVF rates in their facilities. Network 11 has used a variety of formats to deliver this education including workshops, newsletter, distribution of education materials, action plans, and best practices.

   A. **Dialysis unit workshops:** Throughout the Fistula First initiave, facility workshops have been an effective strategy to give facilities the needed tools and resources to impact AVF improvement in each of their facilities. This strategy was launched in 2004 when Network 11 hosted five Fistula First workshops for facility nurses, medical directors, and vascular access coordinators to facilitate the sharing of resources and development of facility quality improvement plans. This strategy has been repeated each year since that time and has enabled Network 11 to improve partnerships with dialysis providers through a focus on AVF rate improvement. In 2010, Network 11 conducted four of these workshops via WebEx. These workshops were each conducted for a regional chain of facilities that were not achieving adequate improvement in AVF prevalence. Nephrologists, surgeons, nurses, social workers, dietitians, and others gathered to brainstorm as a group on strategies to accelerate rates of AVF prevalence. As shown in Figures 2, the workshops facilitated implementaiton of new strategies that enabled signficiant improvement during 2010.

   B. **Facility-Specific Goals:** In 2010, Network 11 continued a strategy, entitled the AVF Goal Project, that used evidence-based interventions to assist all facilities to improve in AVF prevalence, while also moving Network 11 in AVF prevalence to meet the CMS goal. All dialysis facilities eligible to participate in Fistula First were included in the project. Facilities in Network 11 not achieving equal to or higher than 65% AVF prevalence were given a goal based on their December 2009 AVF prevalence rate to achieve by December 2010 data collection. Facilities already meeting the KDOQI recommendation of 65% AVF prevalence were asked to maintain an AVF prevalence rate equal to or above 65%. Facility progress toward their goal was measured monthly, and facilities received comparative data feedback reports quarterly. Facilities not on pace to meet their goal received follow-up from Network 11 quarterly during the first six

Figure 2. AVF Prevalence Improvement for Workshop Facilities, 2010



months, and monthly during the last six months of the project. Facilities not on pace to meet their goal after the first six months were asked to complete a quality improvement plan. Network 11 facilities overall made significant progress toward their facility-specific goals. Overall, 73% of facilities that completed a quality improvement plan after the first six months significantly accelerated their rate of improvement in the second 6-month segment of the project, by improving 3.7% in AVF prevalence.

C. **Site Visits:** In working with facilities in improving AVF rates, Network 11 conducted medical record review and engaged facility teams in strategy development to assist them in improving rates of AVF prevalence. Overall, 16 site visits were conducted on-site at the facility, and four off-site visits were conducted in which the facility was asked to submit documentaiton to Network 11 for review. Both groups showed significant improvement after Network 11's intrevention. See Figures 3 and 4.

Figure 3. AVF Prevalence Improvement for 16 Facilities Receiving On-site Visits, 2010

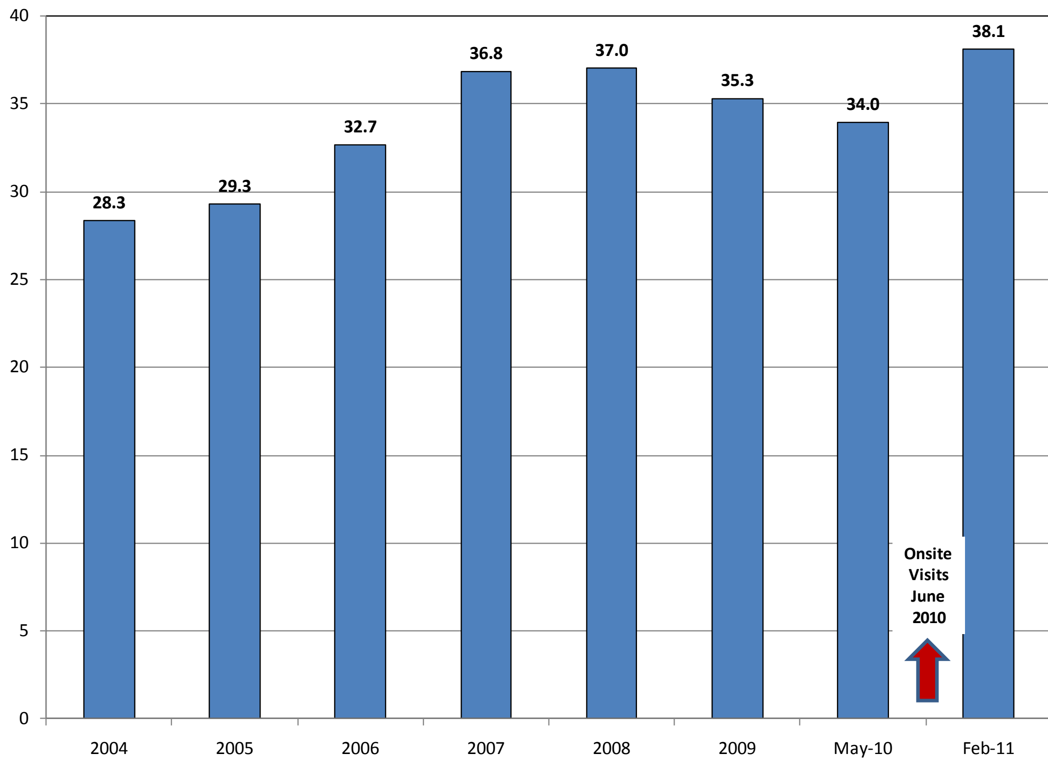
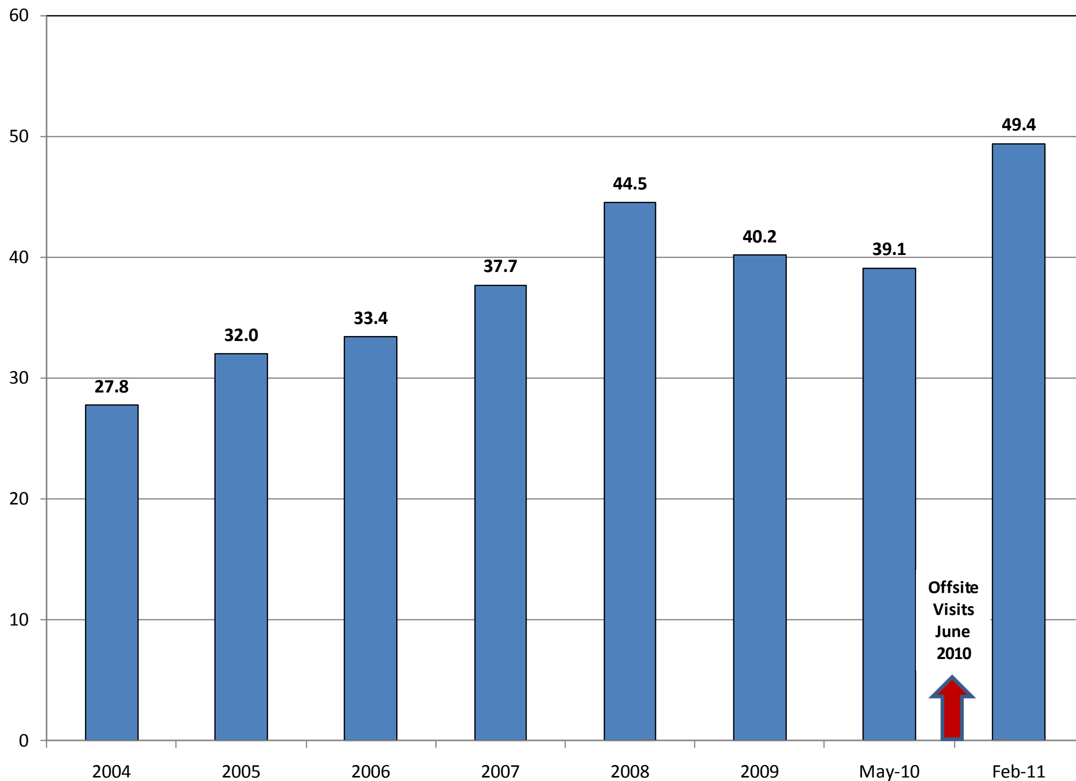


Figure 4. AVF Prevalence Improvement for 4 Facilities Receiving Off-site Visits, 2010



3. **Surgeon Strategies**

Network 11 worked with vascular access surgeons in the region as another way to improve AVF rates. Workshops, data analysis, and education offerings were a few of the ways Network 11 has reached out to surgeons.

A. **Workshops:** At the start of the Fistula First initiative, Network 11 explored ways to partner with members of the surgical community that would assist facilities in improving their rates of AVF prevalence. In 2004, Network 11 conducted a pilot surgeon workshop in Detroit, Michigan focused on partnering nephrologists with surgeons to increase AV fistula placement and use. From the workshop, new partnerships began with vascular access surgeons. As an outcome, new champion surgeons were identified that have been instrumental in the promotion of the Fistula First campaign with other vascular access surgeons. Due to this success, additional surgeon workshops were condcuted in Minneapolis, MN, Milwaukee, WI, and Fargo, ND., as well as a regional surgeon workshop in Chicago, Illinois. This strategy was repeated in 2010, with a national collaborative surgeon workshop in Chicago, Illinois. Network 11 had the highest number of surgeons in attendance.

B. **Network 11 Surgeon Task Force:** Although Network 11 has focused on collaboration with individual surgeons in the Upper Midwest region as a way to improve care, Network 11 realized that more impact could be made by a task force of surgeons working together. In 2006, Network 11 convened a task force of 10 vascular access surgeons who are recognized as champions in AVF placement and patency. Network 11 meets with these surgeons as a group on the listserve and also individually as needed to identify best practice strategies that will assist in improving AVF prevalence in Network 11.

Upper Midwest Fistula First Coalition

Network 11 launched the Upper Midwest Fistula First Coalition in August 2005 to draw strength and resources from other organizations to gain further improvement in AVF placement and use by addressing systems change. The Coalition has continued to develop strategies that will improve vascular access outcomes in Network 11. In 2010, a WebEx on overcoming patient resistance, a vascular access assessment poster, and a vascular access assessment checklist were developed. See coalition section for further details.

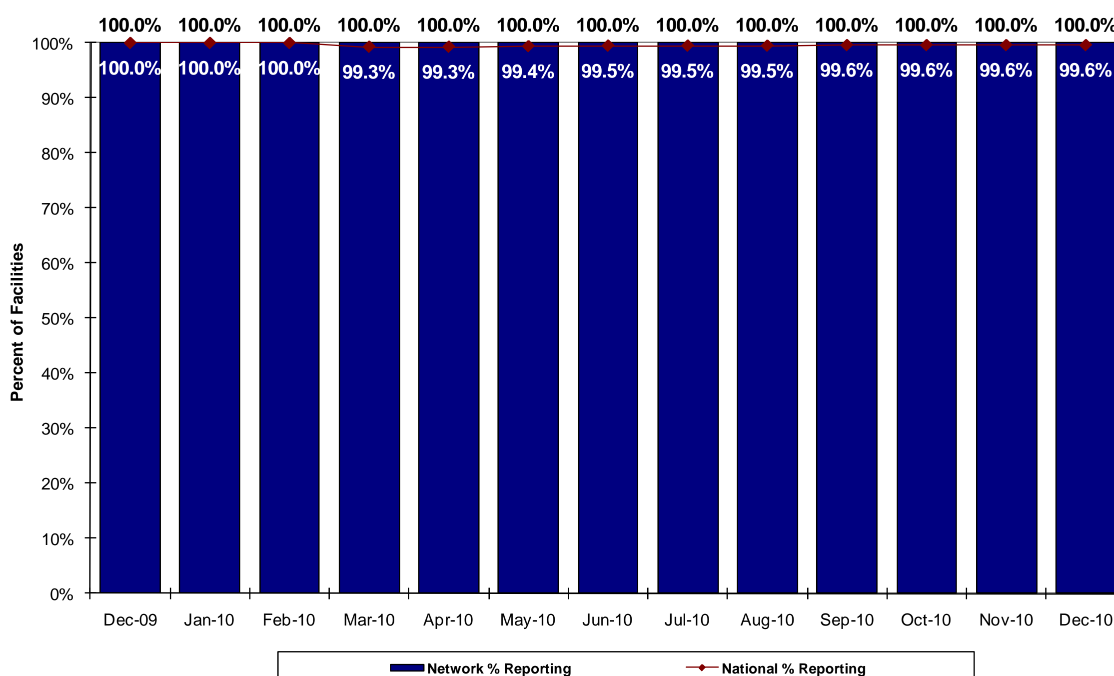
How are data collected, analyzed, and reported?

Data Collection

- **Large dialysis organizations:** Large dialysis organizations transmit monthly reports to a national database, and a national dashboard is maintained. About 203 of 401 Network 11 dialysis facilities (50.6%) have data reported in this way.
- **Non-large dialysis organizations:** About 198 of 401 (49.4%) of Network 11 facilities are not affiliated with large dialysis organizations. Independent and regional dialysis organizations transmit facility-specific aggregate data to Network 11, and these data are forwarded for inclusion in the national database. To accomplish this, a data collection tool was created for facilities to document patient vascular access. Through facility follow-up and support, Network 11 collects data from 100% of its facilities as of December 2010. See Figure 5.

Data Analysis and Reporting

Figure 5. Percentage of Facilities Reporting Fistula First Data, 2010



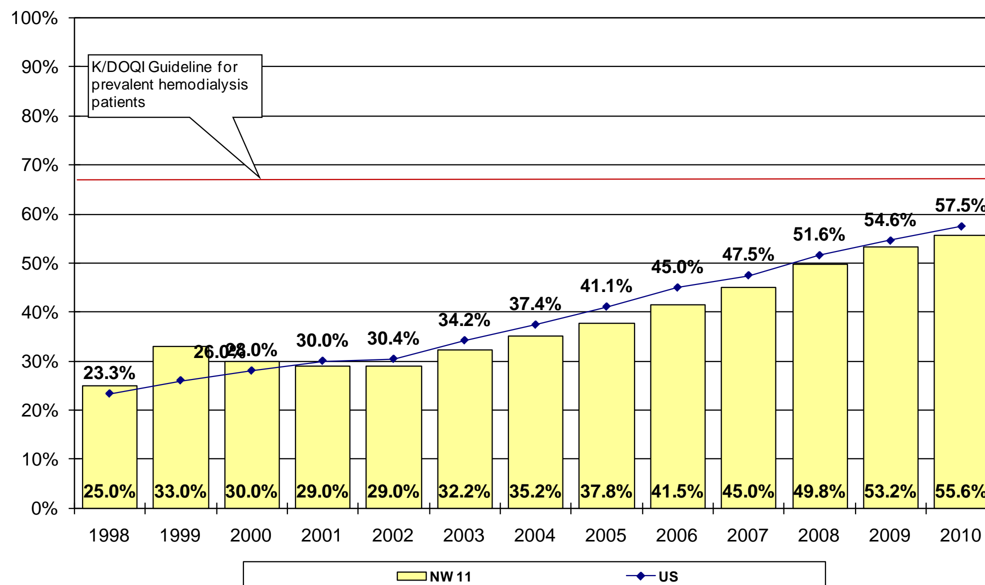
Network 11 collaborates with the national initiative to collect, analyze, and report comparative, facility-specific reports on vascular access practices. The national dashboard is used to report results comparing Network 11 with other Networks in the country. Monthly, Network 11 reviews and reports data from the national dashboard. Quarterly, Network 11 sends facility-specific, comparative reports to each dialysis unit in Network 11. At least annually, Network 11 sends facility-specific reports to each unit with a percentile ranking within Network 11.

How Does Network 11 Compare?

Results in Network 11

- **Annual trends:** Network 11 has tracked vascular access data from 1998 - 2002 through the CDC survey process, and from 2003 - 2010 through the Fistula First initiative. Figure 6 shows a significant increase in the percent of patients dialyzing with an AVF during these

Figure 6. Percentage Patients Dialyzing with an AV Fistula in Network 11, 1998-2010



ten years, especially since the start of the Fistula First initiative.

- **Monthly trends:** Since the beginning of the national Fistula First dashboard, Network 11 has improved the AVF rate by 24.3% (from 31.3% in October 2003 to 55.6% in December 2010). See Figure 1. The percentage of facilities demonstrating higher rates of improvement in AVF rates has continued to rise over the past 12 months. See Figure 7. In addition, the percentage of facilities that have not shown improvement in AVF rates has continued to decline. Network 11 will continue to focus on collaboration among the dialysis facility, surgeon, nephrologist, and patient to increase the percent of patients who are dialyzing with an AVF to at least the KDOQI targets.
- **State trends:** Each of Network 11's states have shown improvement in AVF prevalence over the course of the Fistula First project. Since each of the five states has unique education needs and barriers to achieving AVF improvement, each state was targeted individually for specific interventions to facilitate improvement. Figure 8 shows improvement that has been made in Network 11 by state as of December 2010.

Figure 7. Percentage of Facility AVF Prevalence, 2003-2010

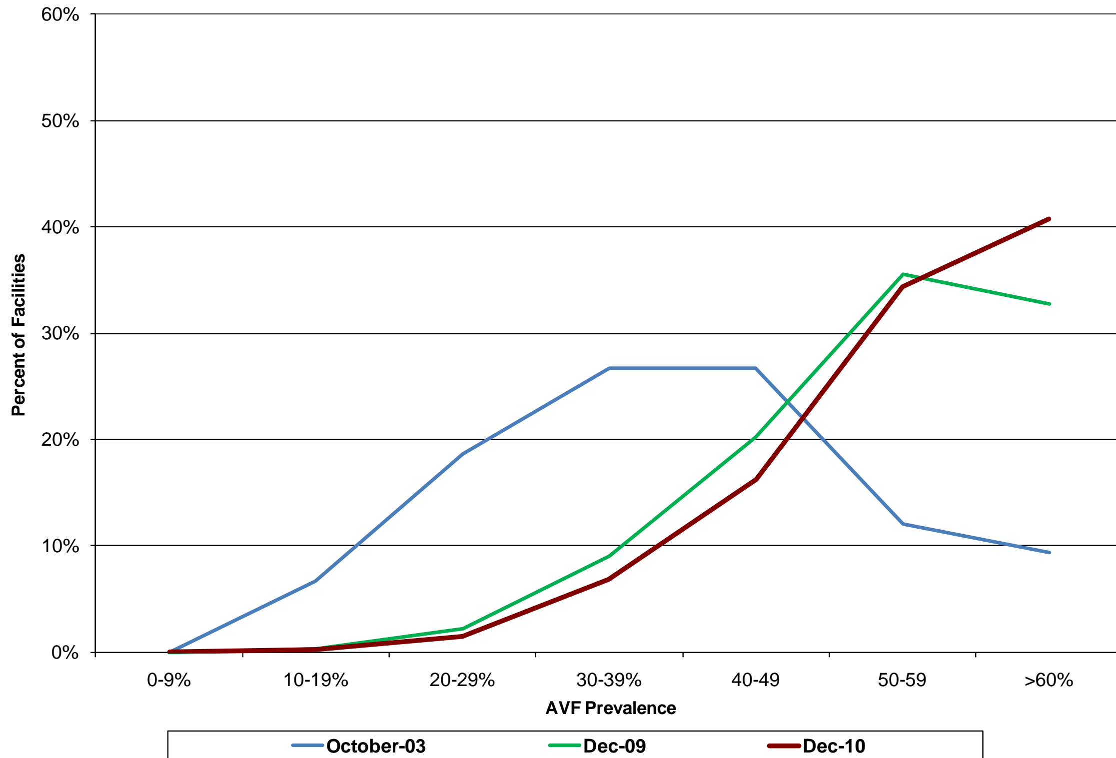
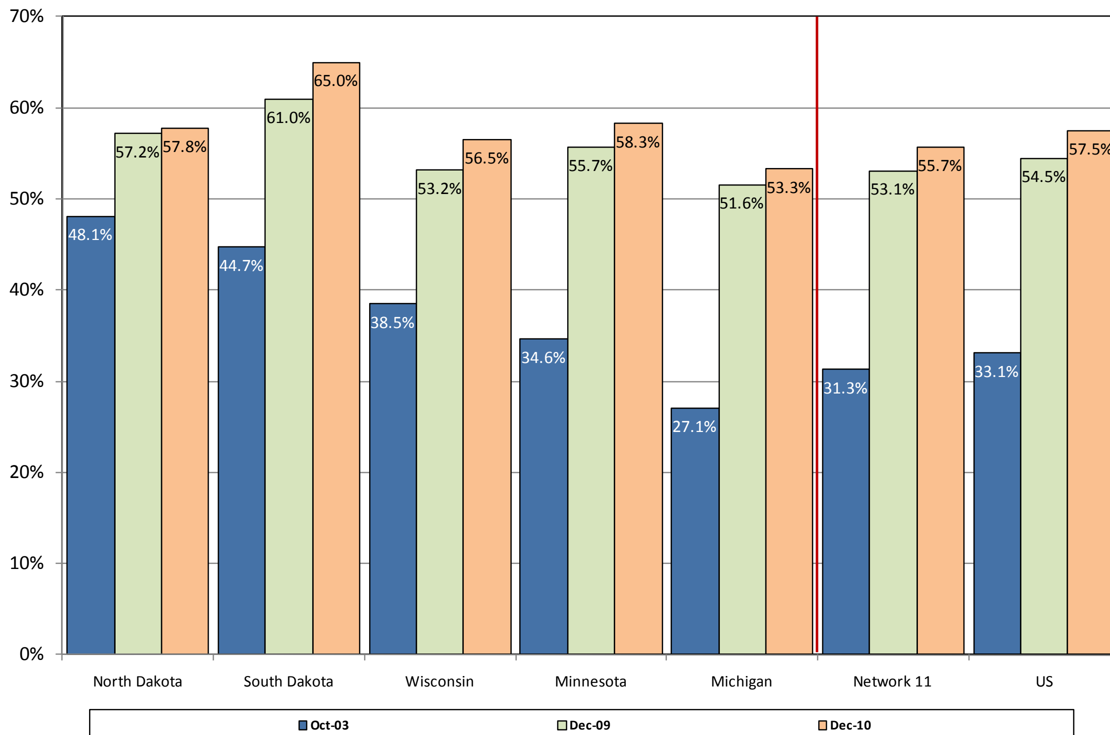


Figure 8. Comparison of Network 11 AVF Improvement by State, 2003 - 2010



National Results

As of December 2010, all Networks have improved the percentage of prevalent dialysis patients using an AVF. Figure 9 shows the progress that Networks have made in AVF prevalence. Nationally, all states have now achieved an AVF rate above 50%, and several are approaching the KDOQI target of 65%. Figure 10 shows where Network 11 ranks among Networks for annual improvement. The eastern and western coasts continue to show the greatest percentages of AVF prevalence.

Figure 9. AVF Prevalence by State, December 2010

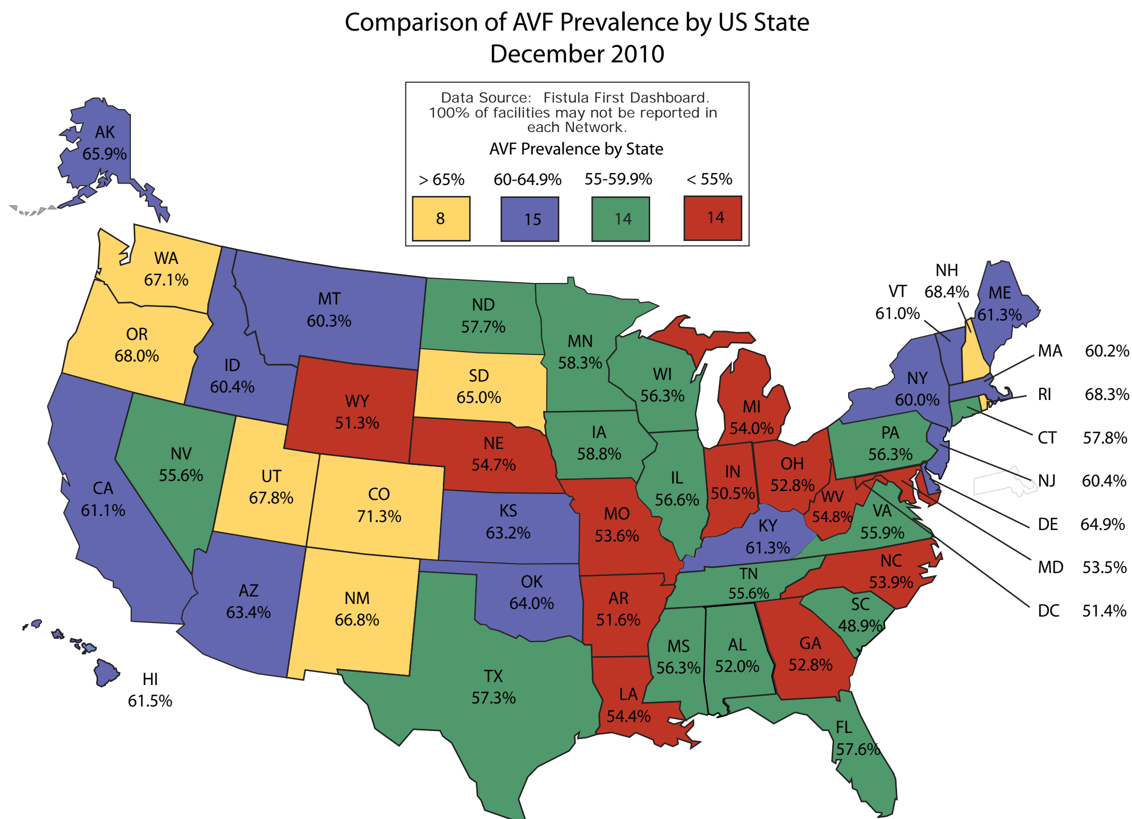
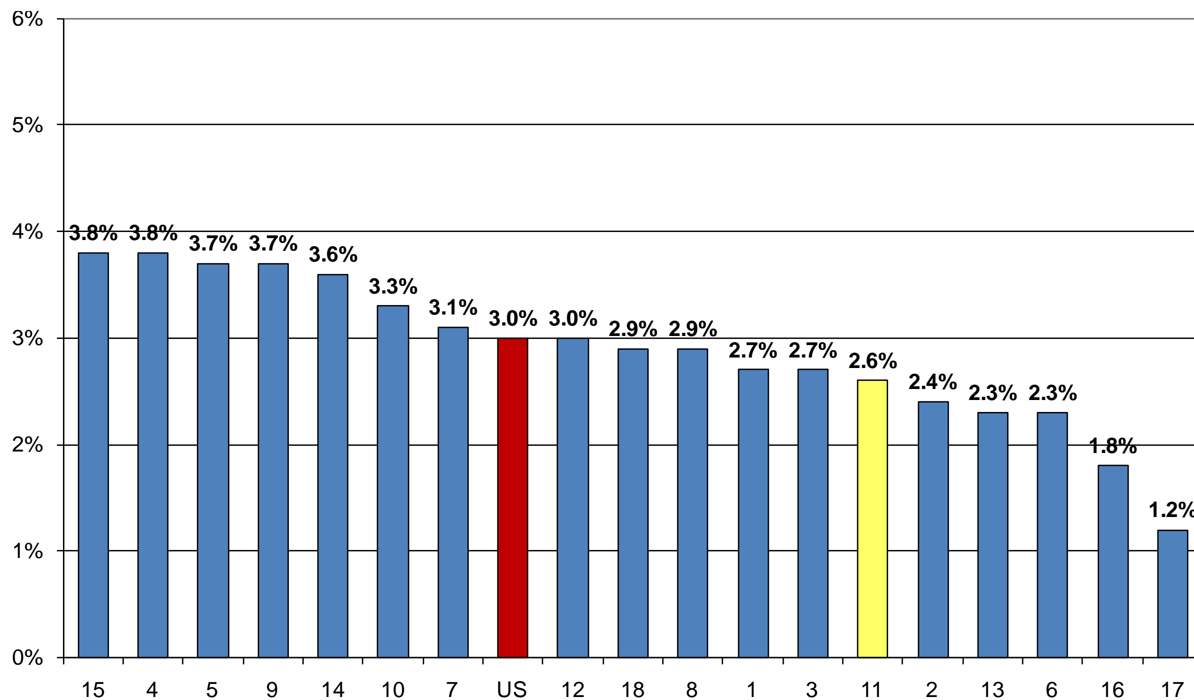


Figure 10. Percent of Absolute AVF Improvement by ESRD Network, December 2009 - December 2010



How Will Network 11 Continue to Meet This Challenge?

Network 11 plans to intensify partnerships with the renal and medical communities to increase AVF placement and function. In 2011, Network 11 plans to:

- Continue focus on facility education focused on cannulation and process improvement.
- Continue and expand education efforts for both patients and facility staff.
- Conduct on-site and off-site facility reviews.
- Encourage and support facility reporting.
- Support the Network 11 Fistula First and Surgeon Task Force in the development and implementation of initiatives.
- Continue to target resources in regions with low AVF rates.
- Develop partnerships with providers, SSAs, surgeons, and others to implement strategies that will facilitate further improvement in AVF placement and use.

For more information on the Fistula First Project,
Visit the national website at http://www.fistulafirst.org or
the Network 11 website at http://www.esrdnet11.org/quality/fistula_first.

Quality Improvement Work Plan Projects

Quality Improvement Work Plan Overview

One of Network 11's most important responsibilities is the annual development and implementation of a Quality Improvement Work Plan (QIWP). A great deal of consideration is invested in topic selection, methods, and implementation strategies. Network 11's plan is developed under the guidance of our Medical Review and Executive Committees. CMS specifies that the Quality Improvement Work Plan must include four components, and Network 11's 2010 Quality Improvement Work Plan was approved by CMS as follows.

CMS Requirements for QIWP	Network 11's 2010-2011 Project Goals
Fistula First Project	1. AVF Rates–Increase the percent of patients dialyzing in Network 11 with an AVF to 55.9% as of March 2011 data.
Projects initiated as a result of the national ESRD CPM Project	2. Decrease missed treatments in selected dialysis facilities
Network-Specific Project	3. Increase the ability of selected dialysis facilities to track and report immunizations.
Facility-Specific Project	4. Assist on-site visit facilities to develop and implement a comprehensive QAPI program.

These projects were designed for completion during August 2010–June 2011. The AVF Project (#1 above) is described in the Fistula First section of this report. The remaining quality improvement projects (# 2–4 above) were each designed as a collaborative with 9–10 dialysis facilities participating per project. Each collaborative included a kick off Webinar, periodic calls to discuss specific aspects of the quality improvement process, monthly reporting, threshold monitoring, and sharing resources and best practices. The three collaborative projects are described in detail as follows.

Hemodialysis Adequacy-Reducing Missed Dialysis Treatments

Background

Hemodialysis adequacy is an important indicator of quality care for patients on hemodialysis. Missing dialysis treatments has a detrimental effect on the adequacy of dialysis. Experts agree that compromising the delivery of prescribed dialysis impacts a patient's morbidity and mortality. Nonadherence to hemodialysis treatment time as prescribed by the nephrologist has been found to be as high as 35% for missing treatments and 32% for shortening treatments. (Kenhaerynch, K, et al. (2007). Prevalence and Consequences of Nonadherence to Hemodialysis Regimens, American Journal of Critical Care, 16, 222-235). Dialysis facility personnel in Network 11 also report nonadherence as a significant problem, but there is no data within Network 11's region to document the magnitude of this concern. Without beginning to address the problem of missed and shortened treatments, facilities will continue to have inadequate resources to address this problem, therefore leaving more patients with inadequate dialysis.

Goal

Five out of nine facilities (55%) will meet their facility specific goal for decreasing the percent of missed treatments by March 30, 2011.

Methods

Network 11 dialysis facilities were surveyed to determine the number of missed treatments in each dialysis facility, as well as in Network 11 as a whole. Based on the results of this environmental scan, 9 facilities were selected from the lowest quartile (most missed treatments) to participate in the project. The data obtained in the scan served as baseline data.

Facilities were asked to participate on an initial web-ex session and conference calls at least quarterly. Network 11 worked with facilities to determine a facility-specific goal for the project. They were also asked to submit monthly data as to the number of missed and total treatments during the calendar month. Facilities were sent a data collection tool to facilitate collecting the information. Each month the facility submited that form to Network 11. At the end of the project (March 2011), improvement was measured by the facility's ability to meet their facility-specific goal.

Implementation

The project was implemented in November 2010 and was concluded in April 2011 (March 2011 data).

Project Results

Network 11 met its goal for this project. Results show that 6/9 (66.7%) facilities improved the number of missed treatments.

Using an Electronic Data Collection Tool to Improve Immunization Reporting

Background

Although Network 11 has shown consistent improvement in immunization rates since 2005 (see table below), the rates continue to be below the Medical Review Committee recommendations and Healthy People 2010 guidelines.

Year	Inluenza	Pneumonia	Hepatitis B
2005-2006	75.6%	58.1%	70.4%
2007-2008	81.3%	64%	83.6%
2009-2010	87.4%	71%	86%

The Safe and Timely Immunization Coalition (STIC) demonstrated that one barrier to reporting an accurate immunization rate was the lack of a consistent method of collecting and reporting immunization data. In spite of the improvement shown above, there continue to be facilities in Network 11 that do not have a method of effectively tracking and documenting immunizations and therefore, are not able to report results.

Goal

7/10 (70%) facilities that currently do not have an immunization tracking system will implement a tracking form and submit immunization data by March 30, 2011.

Methods

The 2009-2010 immunization data collection will be reviewed. Those facilities that were either in the lowest quartile for results or who were not able to submit data will be identified. These facilities will be asked the following questions.

1. Type of tracking method used by their facility
2. Identify facility-specific barrier to tracking immunizations.

Following collection of this information, 10 facilities will be asked to participate in this project.

Implementation

A web-ex session was conducted in October 2010.

- Importance of immunization
- Introduction and instruction regarding tracking tool that will assist to identify patients receiving immunization in the dialysis unit or outside the dialysis unit.

Monthly contact with facilities helped to identify progress and issues on a timely basis.
Conducted conference call in November to share problems and successes

Results

Network 11 met its goal with this project. In April 2011, 9/10 (90%) facilities submitted immunization data to Network 11.

Developing Quality Assessment and Performance Improvement Programs for Facilities Needing On-Site Fistula First Visits

Background

The new Conditions for Coverage (CfC) require all facilities to develop and implement a comprehensive Quality Assessment and Performance Improvement (QAPI) program. The CfC are very specific regarding the components to be included in the program. Many Network 11 facilities continue to struggle to develop and implement the QI process. In addition to having an inadequate QAPI program, a number of Network 11 facilities have not shown significant improvement in their rates of AVF prevalence. This improvement project focused on the using onsite visits to better assist facilities to develop a comprehensive QAPI program that includes all aspects of the CQI process using vascular access as an example of a specific clinical area needing improvement.

Goal

The goal of this project is that 60% (9/12) intervention facilities will develop and implement a comprehensive Quality Assessment and Performance Improvement program that will result in improved AVF outcomes.

Methods

Facilities were identified as needing site visits based on failure to meet the Network 11 annual AVF goal and failure to develop a comprehensive QI action plan. Network 11 then scheduled onsite visits before September 30, 2010. Network 11 used resources from the Fistula First Breakthrough Initiative as well as other resources for the educational session offered during the site visit. Vascular access data was monitored monthly and facilities were contacted on a regular basis to review progress.

Implementation

Onsite visits were conducted and included record review, staff education, meetings with medical directors, and technical assistance with developing comprehensive QAPI program for vascular access. Network 11 then worked with each facility to improve their QAPI process to facilitate sustained AVF improvement.

Results

This project has met its goal. 10/12 facilities have an effective QAPI program in place. Network 11 continues to work with the other two facilities. Network 11 also plans to continue to follow up with each facility monthly to assess progress on the implementation of their plan, as well as to identify if AVF improvement is taking place.

Elab Report Projects

Elab Project Overview

Since 1999, Network 11 has worked with dialysis facilities and the large dialysis organizations (LDOs) to collect data on nearly 100% of patients in all dialysis facilities in Network 11 and other ESRD Networks. This project, known as Elab, began with Network 11, expanded to three Networks, then to five Networks, and then to all Networks. For the Q4 2010 data collection, all 18 ESRD Networks participated in the Elab Data Collection and Reporting Project. This represents 5,645 dialysis facilities and more than 354,164 patients.

Elab Methods

Since 2003, Network 11 has collaborated with CMS and others to coordinate lab data from the Large Dialysis Organizations (LDOs) for all Networks. The LDOs submit data electronically to CMS. A contractor formats the data according to Network 11 specifications and forwards the data to Network 11. Each ESRD Network collects data from its non–LDO facilities and, using CMS approved security measures, submits that data along with a patient demographic file to Network 11. Network 11 staff merges the data to produce facility–specific reports for each Network. All reports provide the facility with state and Network comparisons. Standard reports include the following.

- Facility characteristics
- HD and PD Quality Indicators (tabular and graphic) including
  - Hemoglobin, Transferrin saturation, and Ferritin
  - Urea reduction ratio, HD Kt/V, weekly Kt/V for HHD and PD, creatinine clearance for PD
  - Albumin
  - Phosphorus and calcium
- HD percentile ranking
- PD percentile ranking
- HD means and median report
- PD means and median report
- 3 year trend report (where possible)
- Pediatric reports
- Hemoglobin distribution graph that provides facility distribution of hemoglobin concentration compared with the Network normal distribution curve based on Network-wide data.

CMS Special Project

Since 2008, Network 11 has received an annual contract from CMS to conduct the Elab Data Collection and Reporting Project. National and Trend Reports from each year are available on the Network 11 website http://www.esrdnet11.org/Elab/index.asp. The primary focus of this project is to process facility-specific, comparative reports for all Networks. The National 2010 Elab Report and a National Elab Trends Report for Q4 2010 will be available in summer 2011.

Elab Data Collection in Network 11

For Q4 2010, collection from Network 11 facilities included approximately 421 facilities and 23,914 patients. Facility–specific reports are reviewed annually by the MRC at its spring meeting. Determinations are made based on the MRC Recommended Treatment Goals and the MRC Review Guidelines (see goals section of this report). Results for specific quality indicators may be found in the Clinical Outcomes section of this report.

Network 11 Composite Quality Report

In 2010, Network 11 pilot tested an expansion to the Elab standard report. This report contained two major changes. The first change was to combine the Elab clinical indicators with a variety of quality measures from other sources. The second change to the standard Elab reports was the addition of a ranking system.

Elab Clinical Indicators

- Elab clinical data elements including demographic data
- Fistula First data derived from the Fistula First Outcomes Dashboard
- All Patient Mortality Summary and New Patient Mortality Summary from the most current Dialysis Facility Report
- Hospitalization Summary and Transplantation Summary from the most current Dialysis Facility Report
- Additional Patient Information
  - Nursing home patients
  - Average # of comorbid conditions
  - Influenza vaccinations
  - Number of involuntary discharges
  - Number of involuntary discharges for noncompliance

Wherever possible, data are displayed comparing the facility to the state, Network, and USA. Network percentiles are also included. Following the distribution of the reports, Network 11 conducted an evaluation to determine facility reaction to the new reports. Evaluation results were overwhelmingly positive as follows.

1. I intend to share this report with others on the healthcare team in my facility. **4.8/5**
2. This quality report will be a useful resource for our QAPI program **4.5/5**
3. I found the report format easy to understand and user-friendly. **4/5**

Based on the positive feedback, the Network 11 Composite Quality Report will be used annually to report quality outcomes.

Network 11 Quality Ranking System
Facilities were assessed based on the percent of their patients who met the MRC recommended treatment goals. These measures for assessment were:

- Hemoglobin < 10 gm/dl
- Hemoglobin ≥ 13 gm/dl
- Phosphorus between 3.5 and 5.5 mg/dl
- Albumin ≥ 3.5/3.2
- Calcium ≤ 10.2 mg/dl
- Adequacy
    - URR ≥ 65% OR Kt/V ≥ 1.2 for in-center hemodialysis patients
    - Kt/V ≥ 2.0 for home hemodialysis patients
    - Kt/V ≥ 1.7 for peritoneal dialysis patients
- AV Fistula use
- Catheter use

To adjust for small patient numbers at some facilities, the Bayesian estimator was used. This estimator is equal to (x +1) / (n + 2) where x is the number of patients who met the goal and n is the total number of patients. A ranking was assigned to each facility based on the adjusted percentage, starting with 1 for the "best" percentage and ending with 420 (the number of facilities) for the "worst" percentage. In the case of a tie, the average value of the corresponding rankings was used.

Facilities had eight rankings after repeating this process for each measure. The mean of those 8 rankings was taken to get a facility average ranking. This average ranking was used to get an overall ranking of the facilities and it was also converted into percentiles. For the 2010 report, each of the 8 indicators were also ranked, to allow facilities to understand where improvement was needed.

Clinical Outcomes - Elab Results

Q4 2010 Elab Highlights for Network 11

Q4 2010 Elab for Network 11 includes

- 421 Dialysis facilities
- 23,914 dialysis patients

Dialysis adequacy

- 89.8% had a mean URR ≥ 65%
- 93.7% had a mean Kt/V ≥ 1.2

Anemia management

- 7.5% HD patients had a mean hemoglobin < 10 gm/dL
- 68.6% of all HD patients achieved a mean hemoglobin in the target range of 10-12 gm/dL
- 23.9% of all HD patients had a mean hemoglobin > 12 gm/dL

Bone and mineral metabolism

- 58.5% had mean phosphorus 3.5-5.5 mg/dL
- 83.5% had a mean calcium 8.4-10.2 mg/dL
- 50.1% had mean phosphorus 3.5-5.5 mg/dL AND mean calcium 8.4-10.2 mg/dL

Hemodialysis Adequacy

Hemodialysis adequacy data are collected as part of the Elab Project. Urea Reduction Ratio (URR) and Kt/V data are collected, and results are from Q4 2010. Figures 1 and 2 show Network 11 data for URR and Kt/V trended over time. Figures 3 and 4 show the Network comparison of the percent of patients with URR ≥ 65% and Kt/V ≥ 1.2. Current data trended show stable results for the percent of patients being adequately dialyzed and facility-specific analysis shows fewer facilities with results below the MRC recommendations. The Network 11 Quality Improvement Workplan for 2010-2011 focused one project on assisting facilities to minimize the number of missed treatments. Missed and shortened treatments have a cumulative effect on reducing the adequacy of dialysis received. Continued improvement of hemodialysis adequacy remains a high priority in Network 11.

Figure 1. Percent of Network 11 Patients with URR ≥ 65%, 2002-2010, Elab Project

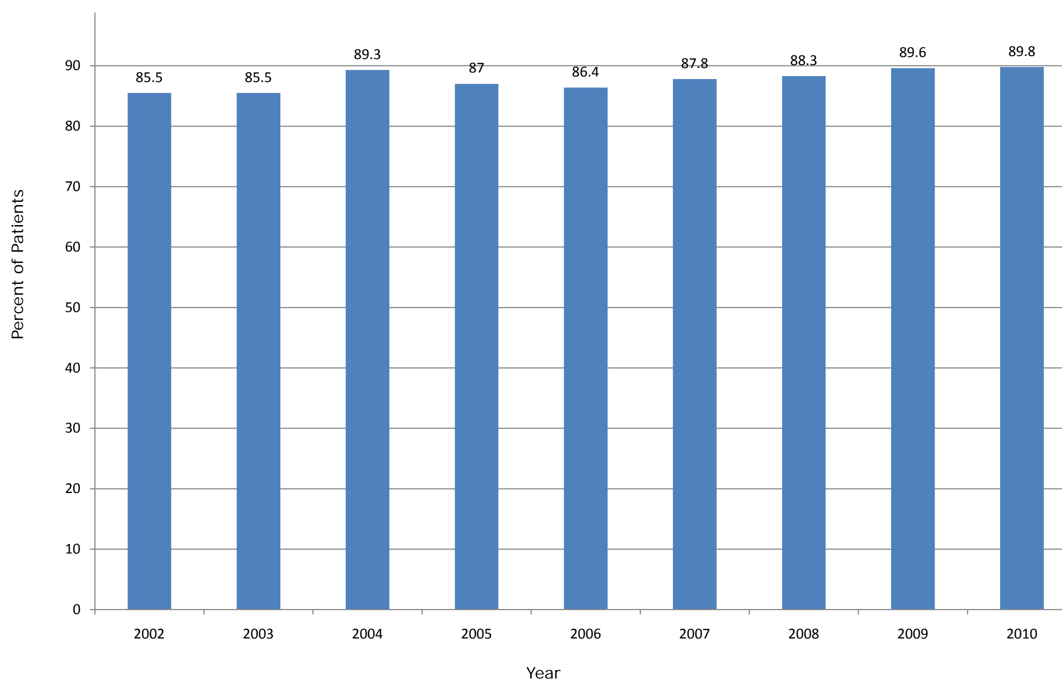


Figure 2. Percent of Network Patients with Kt/V ≥ 1.2, 2002-2010, Elab Project

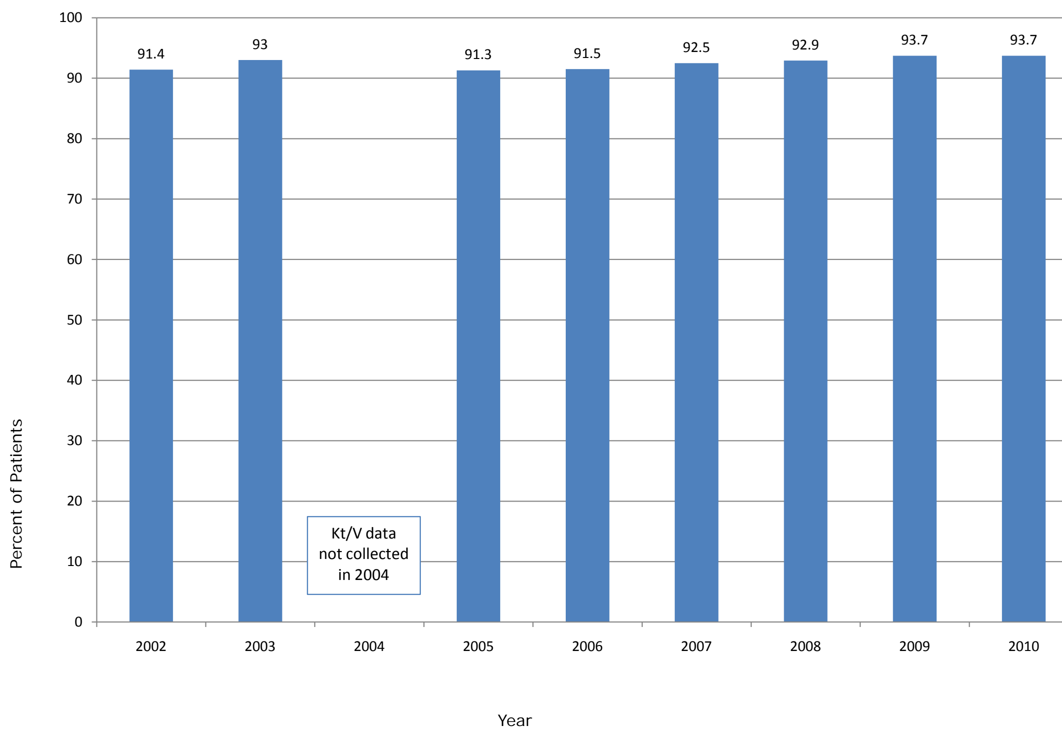


Figure 3. Percent of Patients with URR ≥ 65%, Network 11 and US Comparison, ELab Project, Q4 2010

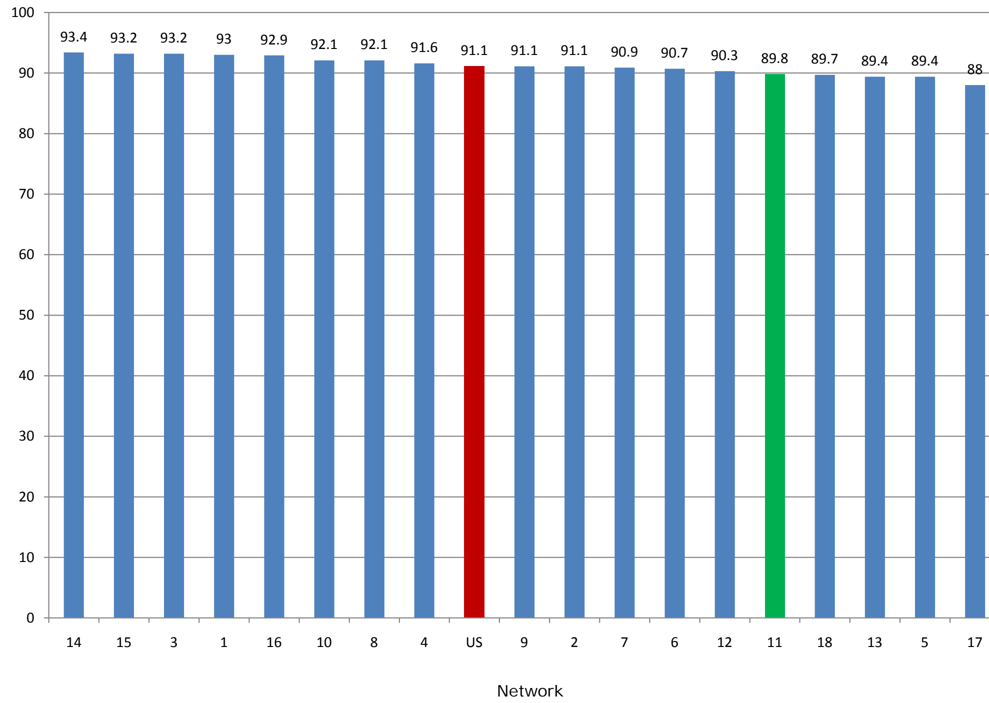
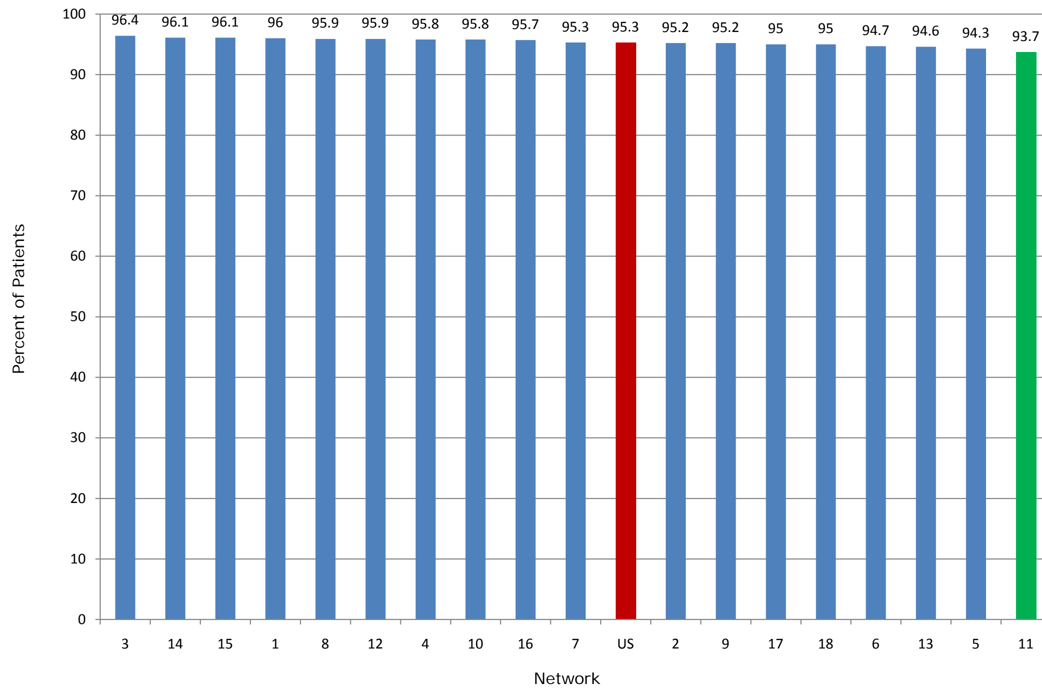


Figure 4. Percent of Patients with Kt/V ≥ 1.2, Network 11 and US Comparison, Elab Project, Q4 2010



Anemia Management

Anemia Management Concerns

Anemia management remains a challenge for dialysis facilities. In addition to the results of research studies such as CHOIR and CREATE, reimbursement changes for Erythropoeisis Stimulating Agents (ESAs) and in 2011, the implementation of the new bundling reimbursement rules have made the management of anemia very complex. The Network 11 MRC encourages facilities to attempt to dose ESAs and IV iron to maximize the percent of patients in the 10-12 gm/dL range recommended by CMS while minimizing the percent of patients with hemoglobin less than 10 or greater than 12 gm/dL.

Network 11 Elab Results

Anemia management data are collected as part of the Elab Project. Figure 5 shows the percent of patients in Network 11 with hemoglobin between 10 and 12 gm/dL, trended over time. Figure 6 shows the percent of patients with Hemoglobin < 10gm/dL as compared to > 12 gm/dL trended over time. Figure 7 shows the normal curve and standard deviation for Network 11 patients, again trended over time. It is interesting to note that the decrease in percent of patients > 12 gm/dL is greater than the increase in patients < 10 gm/dL, as well as to note the decrease in the standard deviation as more patients move into the CMS recommended range of 10-12 gm/dL. While these data demonstrate improvement in anemia management, the advent of the Quality Incentive Program in 2012 will present more challenges, and it will become increasingly important for dialysis facilities to concentrate on balancing ESA and IV iron administration to maintain optimal anemia management outcomes.

Figure 5. Percent of Network 11 Patients with Hgb 10-12 gm/dL, 2002-2010, Elab Project

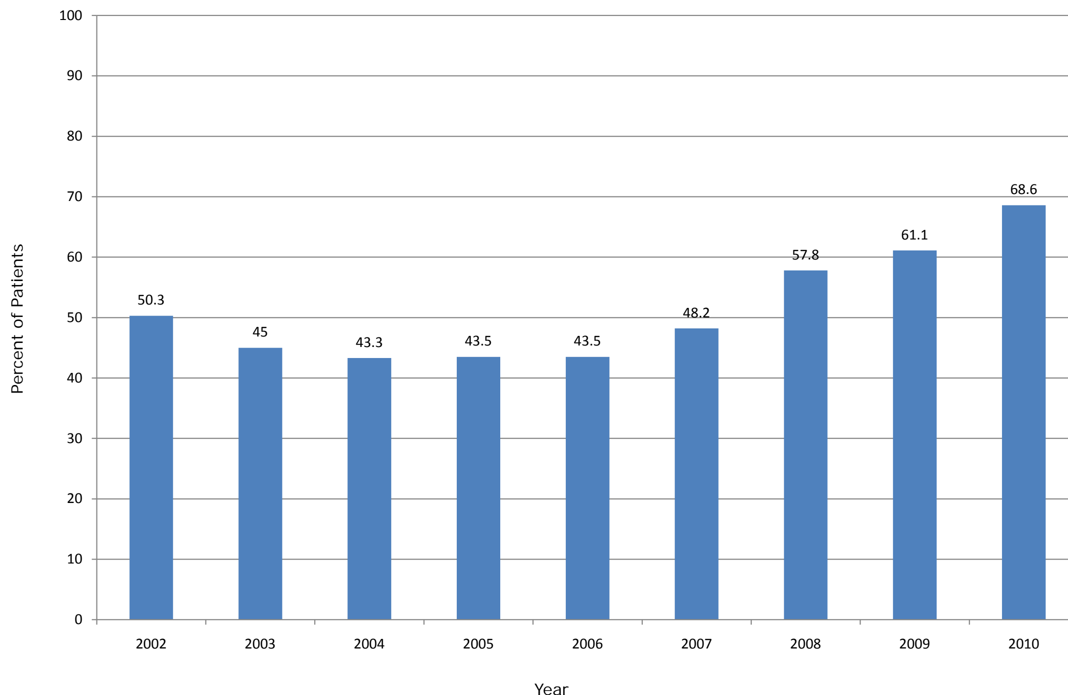


Figure 6. Percent of Network 11 Patients with Hgb <10 gm/dL vs. >12 gm/dL, 2002-2010, Elab Project

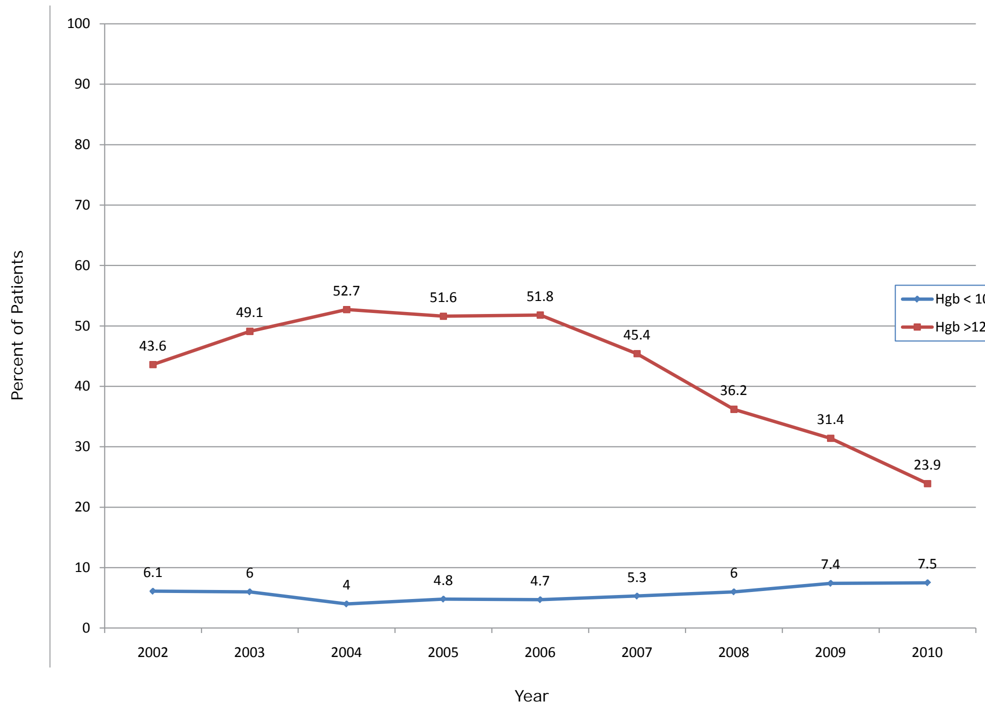
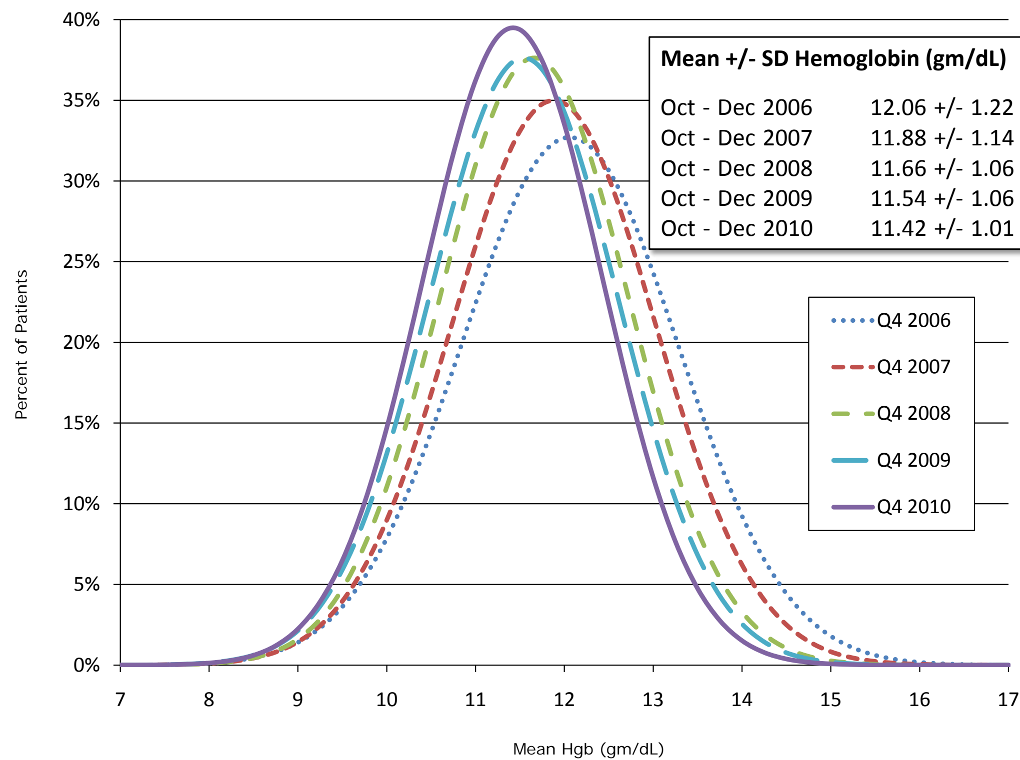


Figure 7. Hemoglobin Distibution by Percent of Network 11 Patients, 2006-2010, Elab Project



Bone and Mineral Metabolism

Network 11 collects phosphorus and calcium data as part of the Elab Project. Figures 8 and 9 show Network 11 data for Phosphorus 3.5-5.5 mg/dL and Calcium 8.4-10.2 mg/dL trended over time. Network 11 has shown consistent improvement in these two indicators since 2002. Figure 10 shows the Network comparison for percent of patients with phosphorus 3.5-5.5 mg/dL for Q4 2010.

Management of bone and mineral metabolism involves balancing several indicators each month. Figure 11 shows percent of patients in Network 11 with both phosphorus 3.5-5.5 mg/dL **and** calcium 8.4-10.2 mg/dL. Again, it is encouraging to see the consistent improvement since 2002. Figure 12 shows the Network comparison for patients with phosphorus 3.5-5.5 mg/dL **and** calcium 8.4-10.2 mg/dL for Q4 2010. Bone and mineral metabolism is a very complex area to manage, and it is an important area of patient management. While Network 11 remains a leader in management of bone and mineral metabolism, these results show continued opportunities for improvement.

Figure 8. Percent of Network 11 Patients with Phosphorus 3.5-5.5 mg/dL, 2002-2010, Elab Project

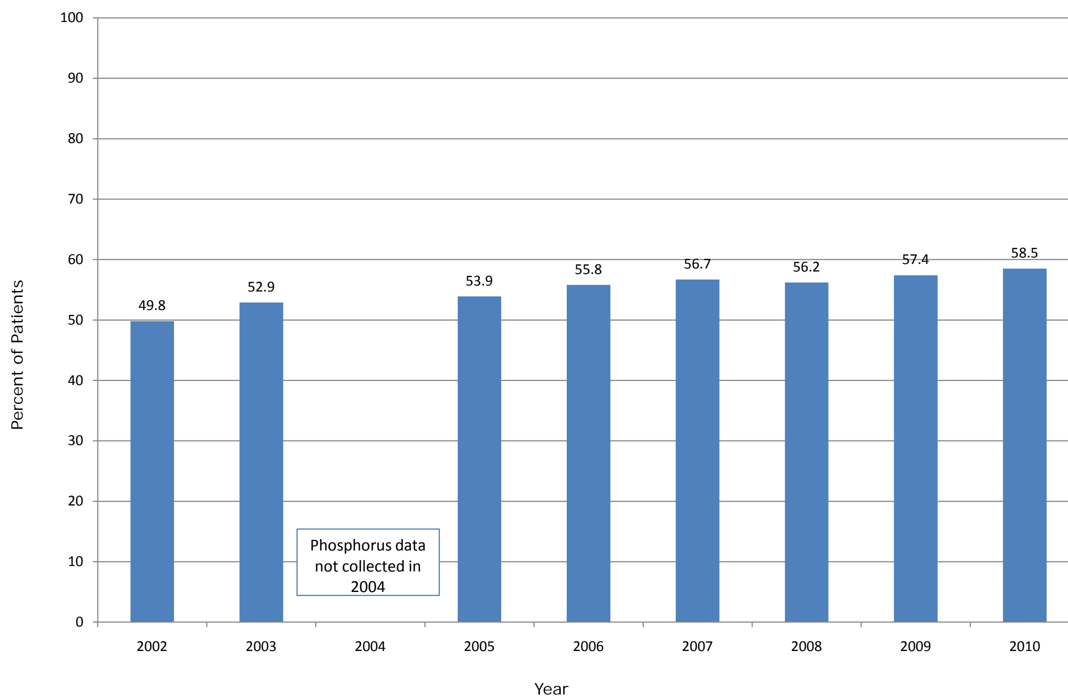


Figure 9. Percent of Network 11 Patients with Calcium 8.4-10.2 mg/dL, 2002-2010, Elab Project

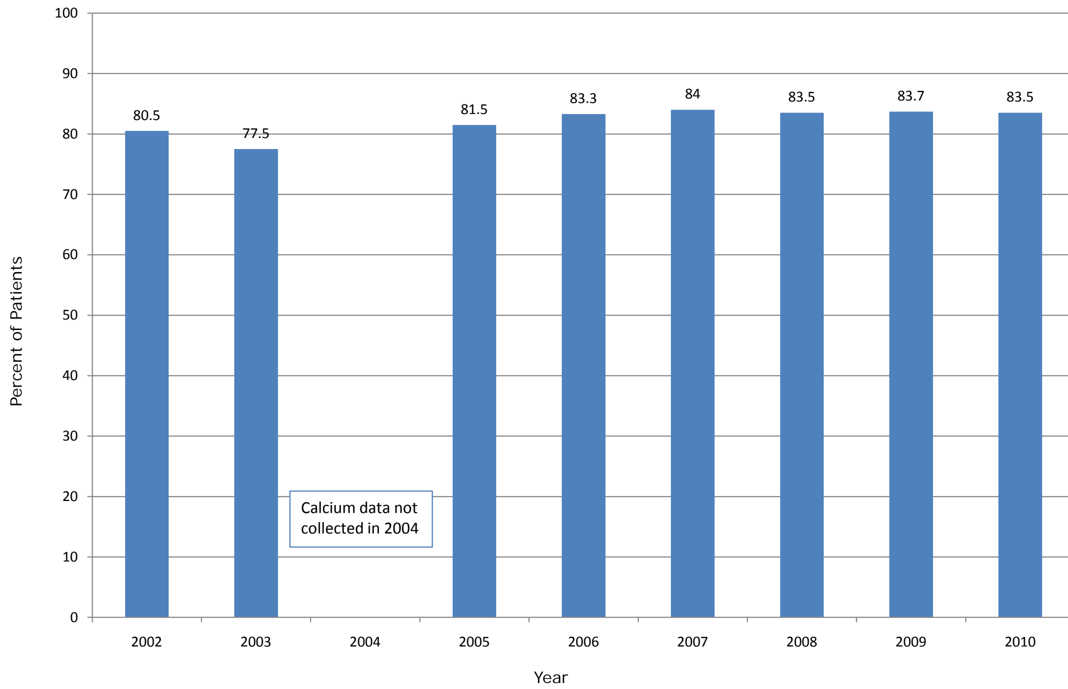


Figure 10. Percent of Patients with Phosphorus 3.5-5.5 mg/dL, National Network Comparison, Elab Project, Q4 2010

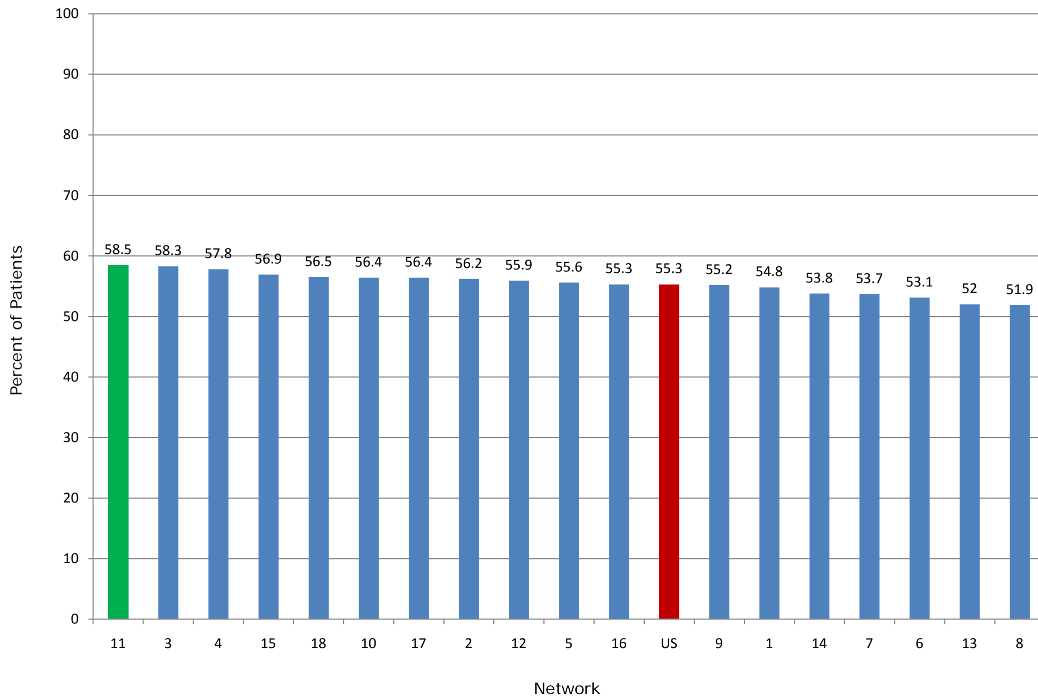


Figure 11. Percent of Network 11 Patients with Phosphorus 3.5-5.5 mg/dL and Calcium 8.4-10.2 mg/dL, 2002-2010, Elab Project

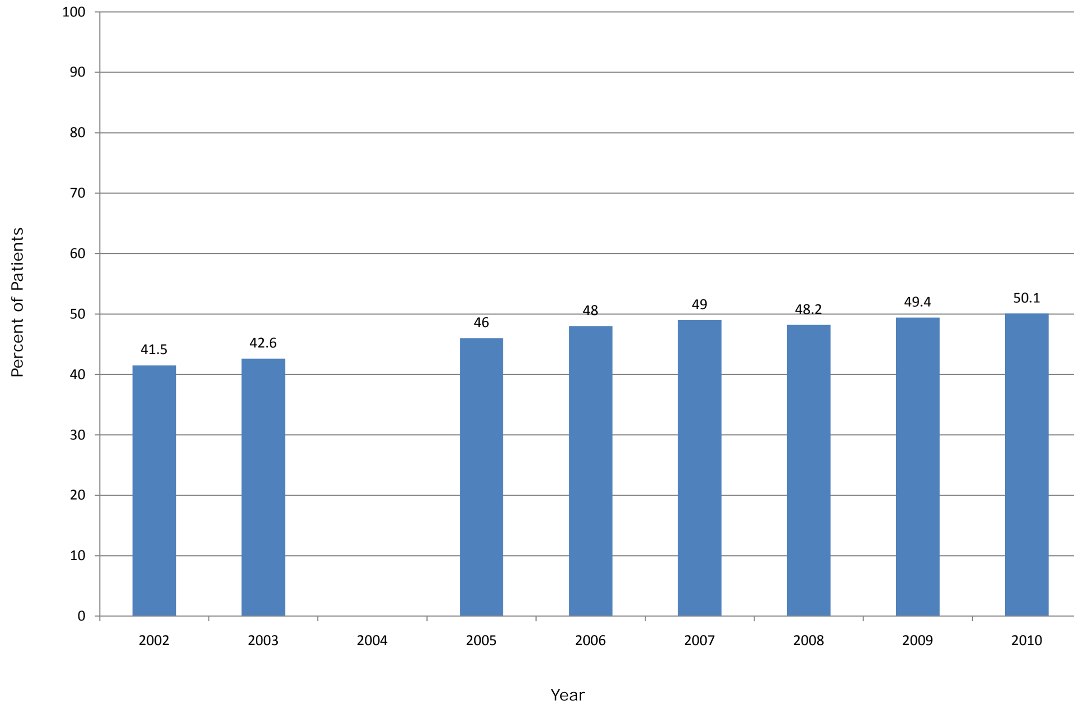
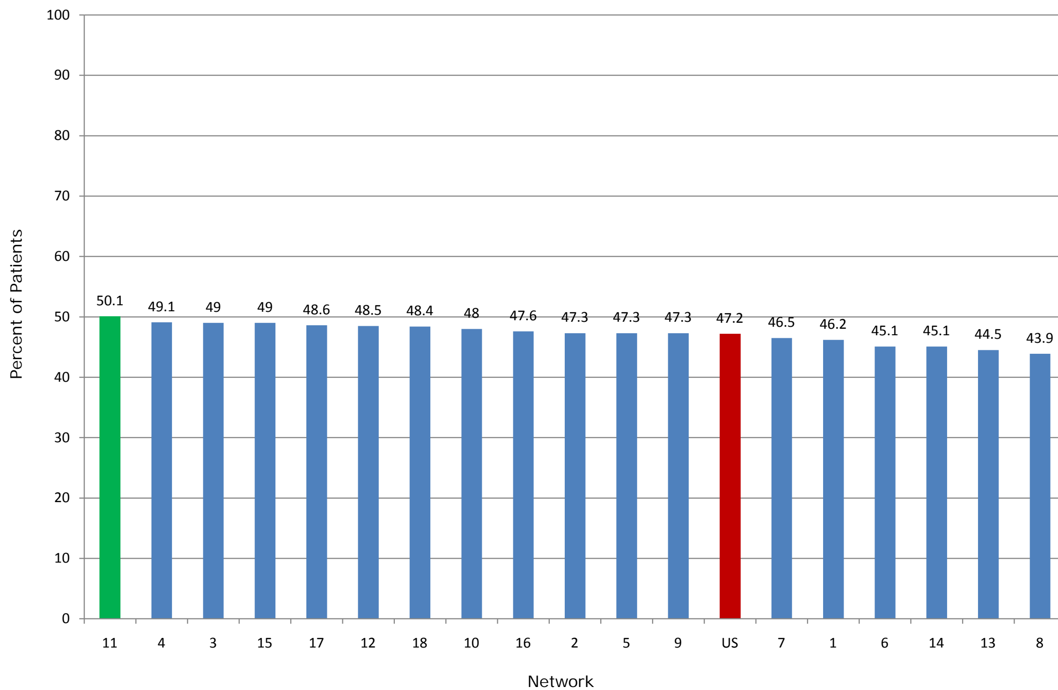


Figure 12. Percent of Patients with Phosphorus 3.5-5.5 mg/dL and Calcium 8.4-10.2 mg/dL, Network 11 and US Comparison, Elab Project



Immunization

Background

Network 11 collects and trends data regarding immunizations for influenza, pneumococcal pneumonia, and hepatitis B. In 2006, the Medical Review Committee added immunization to its recommended treatment guidelines. The guidelines are based on Healthy People 2010 and are as follows.

- ≥ 90% of patients will receive immunization for influenza
- ≥ 80% of patients will receive immunization for pneumonia
- ≥ 80% of patients without natural immunity will receive immunization for hepatitis B

Network 11 facilities continue to improve in percent of patients immunized, however, there remain significant opportunities for improvement in the area of immunization. Network 11 will continue to strive for increased percent of patients immunized.

Percent of Patients Receiving Immunization

Immunization	2005-2006	2006-2007	2007-2008	2009-2010
Influenza	75.6%	81.3%	80.9%	87.4%
Pneumonia	48.7%	64%	63.6%	76.3%
Hepatitus B (complete or partial series)	74.9%	83.6%	82.6%	88%

In addition, Network 11 also collected information regarding immunization for H1N1 Influenza. Although many facilities were unable to obtain vaccine, 46.3% of patients were vaccinated. Network 11 will continue to work with facilities to increase awareness of H1N1 influenza and the need for immunization.

Emergency Preparedness

Background

Natural disasters have had a serious impact on both the general and ESRD populations, as in Hurricane Ike, Hurricane Katrina, and the Red River Floods. With these disasters, a need has arisen for greater focus on how facilities caring for patients should prepare for future emergencies. In response, CMS has included several changes to the Conditions for Coverage to ensure dialysis facilities are prepared should a disaster or emergency occur. Network 11 has also met this need with several strategies to provide assistance and support to facilities developing and implementing their emergency preparedness plan.

How Does Network 11 Assist Facilities During an Emergency?

Network 11 is available to assist dialysis facilities in emergency and disaster events by:

- Accessing regional and national resources to assist facilities in implementing emergency plans in the event of an emergency or disaster. Resource examples include Kidney Community Emergency Resources (KCER), as well as collaboration with state survey agencies and state emergency preparedness offices.
- Assisting facilities in locating dialysis facilities for back-up dialysis treatments.
- Triaging calls from patients and their families to track patient treatment status and, if necessary, treatment relocation.
- Collaborating with state health departments, local and state disaster agencies, and other community organizations to identify the needs of dialysis patients and facilities and providing assistance in meeting those needs.
- Tracking open and closed facility status through www.dialysisunits.com.
- Tracking patient status through the patient registry.

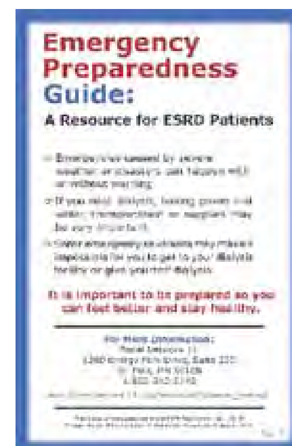
How Does Network 11 Help Dialysis Facilities Develop a Plan for Emergency Preparedness?

Network 11 has developed the following tools and resources to help facilities prepare for emergencies and disasters:

- **Dialysis Facility Disaster Plan Checklist:** A detailed checklist which helps a facility to develop an effective emergency and disaster preparedness plan, including: ensuring facility is emergency-ready, developing an evacuation plan, developing a plan of response during an emergency or disaster, and how to respond when an emergency occurs.
- **County Emergency Management Form:** A form that can be used to communicate needs about your dialysis facility and patients to your local disaster management agency. Having this information will assist local disaster agencies to meet the needs of dialysis patients and facilities when an emergency occurs. Facilities are encouraged to submit this form to their local disaster agency at least annually.
- **Letter to Power Company Template:** A template that can be used to communicate needs about a dialysis facility and its patients to the local power company.
- **Letter to Water Utility Agency Template:** A template that can be used to communicate needs about a dialysis facility and its patients to the local water utility company.

- **Patient Guide:** Network 11 developed a guide that assists patients to become more prepared for an emergency. The booklet includes a general overview for patients on how to prepare for emergencies, and also gives specific actions that can be taken in the areas of medications, diet, dialysis and medical treatment, as well as keeping an emergency supply list.

- **Local Emergency Response Program Contact Listing by State:** Each dialysis facility was given a list of local disaster agencies in their community. This listing will enable dialysis facilities to begin and maintain ongoing contact to ensure facility and patients needs will be met when an emergency occurs.



Patient Guide on Emergency Preparedness

What Is Network 11 Doing to Help My Facility and Patients Stay Prepared?

To address the ongoing need to provide additional tools and resources to dialysis facilities, Network 11 has implemented a number of strategies:

- Network 11 participates with the Kidney Community Emergency Response Coalition (KCER) to access additional tools and resources that can be shared with Network 11 facilities. Examples of tools that have been distributed to facilities in collaboration with KCER include the Lavender Patient Card, template letters, education guides, and patient and staff brochures.
- All new facilities receive resources on emergency planning as part of the new provider packet.
- In early 2009, and again in 2010, Network 11 facilities received written correspondence outlining the various resources available on Network 11's Website to assist them with emergency planning.
- Network 11 facilities receive written correspondence outlining the new requirements in emergency planning as defined by the Conditions for Coverage..
- Network 11 collects forms from all new facilities designating a primary and a back-up disaster coordinator so that Network 11 is able to communicate quickly with each facility when an emergency occurs.
- Network 11 maintains contacts with each of the state emergency preparedness offices, CMS, CDC, state survey agencies, and others so that the latest information on emergency and disaster status is spread to Network 11 facilities.
- Provides a listing of resources via Network 11's Website that will assist facilities to both prepare for an emergency and implement their emergency preparedness plan when an emergency occurs.

What is Network 11 Planning Next?

Network 11 plans to continue to provide assistance to facilities that will both improve each facility's plan for emergency preparedness, and also give facilities the necessary tools and resources to develop and implement an effective plan:

- Collaborate with local disaster agencies by identifying dialysis facilities and patients residing in their jurisdiction, and by providing education to these agencies about the needs of ESRD patients during an emergency or disaster.
- Partner with state emergency preparedness offices to relay the needs of dialysis facilities during an emergency, and to work toward having ESRD patients recognized as a vulnerable population within each state's plan.
- Work with local, state, and national agencies and coalitions to access tools and resources that are effective for use in dialysis facilities and with ESRD populations.
- Continue to provide technical assistance, support, tools, and resources to Network 11 facilities; assisting them with having effective plans in place for emergency preparedness.
- Facilitate communication among those involved in pending emergencies such as flooding
- Translate the Emergency Preparedness Guide into Spanish in 2011.

For more information about Network 11's Emergency Preparedness Initiatives, please visit:
http://www.esrdnet11.org/resources/disaster_prep.asp

First–Year Outcomes of Renal Transplants Performed by Transplant Centers in Network 11

Background

The Medical Review Committee of Network 11 established a policy to report first year outcomes of renal transplants performed in Network 11 on an annual basis. These reports supplement the Center-Specific Reports published by the United States Renal Data System (USRDS). The USRDS Center-Specific Reports include multi-year, multivariate analyses of national comparative survival, as well as era results for survival rates at 1 month, 1–year, and 3 years, adjusted for many variables. Center-Specific Reports can be found on the Scientific Registry of Transplant Recipients Website at www.ustransplant.org.

First–year outcome reports aid Network 11 by:

- Minimizing lost to follow-up rates.
- Providing historical data for trending and comparative analysis at the center, state, and Network levels, which include the most current year.
- Allowing for MRC review of 3-year trends to identify centers that have confirmed functioning rates that are significantly lower than expected.

Methods

Transplant centers are required to register all kidney transplants performed, and quarterly report any status changes (i.e., return to dialysis, re-transplant, or recovered function) to the United Network for Organ Sharing (UNOS). The data are downloaded and used to update the Network 11 patient registry. Before the first-year outcomes are reported, Network 11 generates patient status worksheets for the calendar year and submits them to the individual transplant centers for verification and update.

First Year Outcomes for Transplants in 2009

The transplant section of the data tables in this report contains first-year outcomes for all 2009 kidney transplants combined, for deceased donor transplants, and for living donor (related and unrelated) transplants. The data are actual, not actuarial, and represent first-year outcomes only. For a more comprehensive review, multi-year and multivariate analyses are needed.

Comparative Performance of Facilities
All Kidney Transplants

First–year outcomes of transplants performed in Network 11 in 2009.

	One Year Status												
	Number of Transplants	Death		Return to Dialysis		Retransplant		Lost to Follow-Up		Recovered Function		Confirmed Functioning	
		#	%	#	%	#	%	#	%	#	%	#	%
MICHIGAN PROVIDERS													
BEAUMONT HOSPITAL TRANSPLANT CTR	68	0	0	3	4.4	0	0	0	0	0	0	65	95.6
CHILDRENS OF MI TRANSPLANT	8	0	0	1	12.5	0	0	0	0	0	0	7	87.5
DEVOS CHILDRENS HOSP - TRANSPLANT	6	0	0	0	0	0	0	0	0	0	0	6	100.0
HARPER UNIVERSITY HOSPITAL TRANSPLANT	38	0	0	2	5.3	1	2.6	0	0	0	0	35	92.1
HENRY FORD HOSPITAL TRANSPLANT	116	7	6	1	0.9	0	0	0	0	0	0	108	93.1
ST JOHN HOSPITAL - TRANSPLANT	55	2	3.6	0	0	0	0	0	0	0	0	53	96.4
ST MARYS HEALTHCARE - TRANSPLANT	92	1	1.1	5	5.4	0	0	0	0	0	0	86	93.5
UNIV OF MI TRANSPLANT	233	10	4.3	10	4.3	0	0	4	1.7	1	0.4	208	89.3
MI TOTALS	**616**	**20**	**3.2**	**22**	**3.6**	**1**	**0.2**	**4**	**0.6**	**1**	**0.2**	**568**	**92.2**
MINNESOTA PROVIDERS													
ABBOTT NORTHWESTERN TRANSPLANT	19	1	5.3	0	0	0	0	0	0	0	0	18	94.7
HENNEPIN COUNTY MED CTR TRANSP	88	5	5.7	1	1.1	0	0	1	1.1	0	0	81	92.0
MAYO ROCHESTER METHODIST - TRANSPLANT	159	1	0.6	2	1.3	1	0.6	0	0	0	0	155	97.5
ST MARYS HOSPITAL TRANSPLANT	10	0	0	0	0	0	0	1	10	0	0	9	90.0
U OF MN MED CTR, FAIRVIEW - TRANSPLANT	201	7	3.5	3	1.5	0	0	0	0	1	0.5	190	93.5
MN TOTALS	**477**	**14**	**2.9**	**6**	**1.3**	**1**	**0.2**	**2**	**0.4**	**1**	**0.2**	**453**	**94.5**
NORTH DAKOTA PROVIDERS													
MEDCENTER ONE TRANSPLANT	13	0	0	0	0	1	7.7	0	0	0	0	12	92.3
SANFORD TRANSPLANT - FARGO	33	0	0	1	3	0	0	0	0	1	3	31	93.9
ND TOTALS	**46**	**0**	**0**	**1**	**2.2**	**1**	**2.2**	**0**	**0**	**1**	**2.2**	**43**	**93.5**
SOUTH DAKOTA PROVIDERS													
AVERA MCKENNAN TRANSPLANT INSTITUTE	31	1	3.2	1	3.2	0	0	0	0	0	0	29	93.5
SANFORD HEALTH - TRANSPLANT UNIT	16	1	6.3	1	6.3	0	0	0	0	0	0	14	87.5
SD TOTALS	**47**	**2**	**4.3**	**2**	**4.3**	**0**	**0**	**0**	**0**	**0**	**0**	**43**	**91.5**
WISCONSIN PROVIDERS													
CHILDRENS OF WI TRANSPLANT	6	0	0	0	0	0	0	0	0	0	0	6	100.0
FROEDTERT MEMORIAL HOSP TRANSPLANT	97	6	6.2	2	2.1	0	0	0	0	1	1	88	90.7
ST LUKES RENAL TRANSPLANT CTR	37	4	10.8	0	0	0	0	0	0	0	0	33	89.2
UNIV OF WI TRANSPLANT	295	6	2	5	1.7	2	0.7	2	0.7	0	0	280	94.9
WI TOTALS	**435**	**16**	**3.7**	**7**	**1.6**	**2**	**0.5**	**2**	**0.5**	**1**	**0.2**	**407**	**93.6**
NETWORK 11 TOTALS	**1621**	**52**	**3.2**	**38**	**2.3**	**5**	**0.3**	**8**	**0.5**	**4**	**0.2**	**1514**	**93.4**

Comparative Performance of Facilities
Deceased Donor Kidney Transplants

First–year outcomes of transplants performed in Network 11 in 2009

	Number of Transplants	One Year Status											
		Death		Return to Dialysis		Retransplant		Lost to Follow-Up		Recovered Function		Confirmed Functioning	
		#	%	#	%	#	%	#	%	#	%	#	%
MICHIGAN PROVIDERS													
BEAUMONT HOSPITAL TRANSPLANT CTR	47	0	0	3	6.4	0	0	0	0	0	0	44	93.6
CHILDRENS OF MI TRANSPLANT	6	0	0	1	16.7	0	0	0	0	0	0	5	83.3
DEVOS CHILDRENS HOSP - TRANSPLANT	1	0	0	0	0	0	0	0	0	0	0	1	100.0
HARPER UNIVERSITY HOSPITAL TRANSPLANT	33	0	0	1	3	1	3	0	0	0	0	31	93.9
HENRY FORD HOSPITAL TRANSPLANT	86	5	5.8	1	1.2	0	0	0	0	0	0	80	93.0
ST JOHN HOSPITAL - TRANSPLANT	38	2	5.3	0	0	0	0	0	0	0	0	36	94.7
ST MARYS HEALTHCARE - TRANSPLANT	57	1	1.8	3	5.3	0	0	0	0	0	0	53	93.0
UNIV OF MI TRANSPLANT	135	7	5.2	8	5.9	0	0	2	1.5	1	0.7	117	86.7
MI TOTALS	**403**	**15**	**3.7**	**17**	**4.2**	**1**	**0.2**	**2**	**0.5**	**1**	**0.2**	**367**	**91.1**
MINNESOTA PROVIDERS													
ABBOTT NORTHWESTERN TRANSPLANT	4	1	25	0	0	0	0	0	0	0	0	3	75.0
HENNEPIN COUNTY MED CTR TRANSP	30	3	10	0	0	0	0	0	0	0	0	27	90.0
MAYO ROCHESTER METHODIST - TRANSPLANT	42	0	0	1	2.4	0	0	0	0	0	0	41	97.6
ST MARYS HOSPITAL TRANSPLANT	4	0	0	0	0	0	0	1	25	0	0	3	75.0
U OF MN MED CTR, FAIRVIEW - TRANSPLANT	112	5	4.5	3	2.7	0	0	0	0	1	0.9	103	92.0
MN TOTALS	**192**	**9**	**4.7**	**4**	**2.1**	**0**	**0**	**1**	**0.5**	**1**	**0.5**	**177**	**92.2**
NORTH DAKOTA PROVIDERS													
MEDCENTER ONE TRANSPLANT	6	0	0	0	0	1	16.7	0	0	0	0	5	83.3
SANFORD TRANSPLANT - FARGO	16	0	0	1	6.3	0	0	0	0	0	0	15	93.8
ND TOTALS	**22**	**0**	**0**	**1**	**4.5**	**1**	**4.5**	**0**	**0**	**0**	**0**	**20**	**90.9**
SOUTH DAKOTA PROVIDERS													
AVERA MCKENNAN TRANSPLANT INSTITUTE	30	1	3.3	1	3.3	0	0	0	0	0	0	28	93.3
SANFORD HEALTH - TRANSPLANT UNIT	6	0	0	0	0	0	0	0	0	0	0	6	100.0
SD TOTALS	**36**	**1**	**2.8**	**1**	**2.8**	**0**	**0**	**0**	**0**	**0**	**0**	**34**	**94.4**
WISCONSIN PROVIDERS													
CHILDRENS OF WI TRANSPLANT	2	0	0	0	0	0	0	0	0	0	0	2	100.0
FROEDTERT MEMORIAL HOSP TRANSPLANT	64	6	9.4	1	1.6	0	0	0	0	1	1.6	56	87.5
ST LUKES RENAL TRANSPLANT CTR	24	3	12.5	0	0	0	0	0	0	0	0	21	87.5
UNIV OF WI TRANSPLANT	209	5	2.4	5	2.4	2	1	1	0.5	0	0	196	93.8
WI TOTALS	**299**	**14**	**4.7**	**6**	**2**	**2**	**0.7**	**1**	**0.3**	**1**	**0.3**	**275**	**92.0**
NETWORK 11 TOTALS	**952**	**39**	**4.1**	**29**	**3**	**4**	**0.4**	**4**	**0.4**	**3**	**0.3**	**873**	**91.7**

Comparative Performance of Facilities
Living Donor Kidney Transplants

First–year outcomes of transplants performed in Network 11 in 2009

	Number of Transplants	One Year Status											
		Death		Return to Dialysis		Retransplant		Lost to Follow-Up		Recovered Function		Confirmed Functioning	
		#	%	#	%	#	%	#	%	#	%	#	%
MICHIGAN PROVIDERS													
BEAUMONT HOSPITAL TRANSPLANT CTR	21	0	0	0	0	0	0	0	0	0	0	21	100.0
CHILDRENS OF MI TRANSPLANT	2	0	0	0	0	0	0	0	0	0	0	2	100.0
DEVOS CHILDRENS HOSP - TRANSPLANT	5	0	0	0	0	0	0	0	0	0	0	5	100.0
HARPER UNIVERSITY HOSPITAL TRANSPLANT	5	0	0	1	20	0	0	0	0	0	0	4	80.0
HENRY FORD HOSPITAL TRANSPLANT	30	2	6.7	0	0	0	0	0	0	0	0	28	93.3
ST JOHN HOSPITAL - TRANSPLANT	17	0	0	0	0	0	0	0	0	0	0	17	100.0
ST MARYS HEALTHCARE - TRANSPLANT	35	0	0	2	5.7	0	0	0	0	0	0	33	94.3
UNIV OF MI TRANSPLANT	98	3	3.1	2	2	0	0	2	2	0	0	91	92.9
MI TOTALS	**213**	**5**	**2.3**	**5**	**2.3**	**0**	**0**	**2**	**0.9**	**0**	**0**	**201**	**94.4**
MINNESOTA PROVIDERS													
ABBOTT NORTHWESTERN TRANSPLANT	15	0	0	0	0	0	0	0	0	0	0	15	100.0
HENNEPIN COUNTY MED CTR TRANSP	58	2	3.4	1	1.7	0	0	1	1.7	0	0	54	93.1
MAYO ROCHESTER METHODIST - TRANSPLANT	117	1	0.9	1	0.9	1	0.9	0	0	0	0	114	97.4
ST MARYS HOSPITAL TRANSPLANT	6	0	0	0	0	0	0	0	0	0	0	6	100.0
U OF MN MED CTR, FAIRVIEW - TRANSPLANT	89	2	2.2	0	0	0	0	0	0	0	0	87	97.8
MN TOTALS	**285**	**5**	**1.8**	**2**	**0.7**	**1**	**0.4**	**1**	**0.4**	**0**	**0**	**276**	**96.8**
NORTH DAKOTA PROVIDERS													
MEDCENTER ONE TRANSPLANT	7	0	0	0	0	0	0	0	0	0	0	7	100.0
SANFORD TRANSPLANT - FARGO	17	0	0	0	0	0	0	0	0	1	5.9	16	94.1
ND TOTALS	**24**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**4.2**	**23**	**95.8**
SOUTH DAKOTA PROVIDERS													
AVERA MCKENNAN TRANSPLANT INSTITUTE	1	0	0	0	0	0	0	0	0	0	0	1	100.0
SANFORD HEALTH - TRANSPLANT UNIT	10	1	10	1	10	0	0	0	0	0	0	8	80.0
SD TOTALS	**11**	**1**	**9.1**	**1**	**9.1**	**0**	**0**	**0**	**0**	**0**	**0**	**9**	**81.8**
WISCONSIN PROVIDERS													
CHILDRENS OF WI TRANSPLANT	4	0	0	0	0	0	0	0	0	0	0	4	100.0
FROEDTERT MEMORIAL HOSP TRANSPLANT	33	0	0	1	3	0	0	0	0	0	0	32	97.0
ST LUKES RENAL TRANSPLANT CTR	13	1	7.7	0	0	0	0	0	0	0	0	12	92.3
UNIV OF WI TRANSPLANT	86	1	1.2	0	0	0	0	1	1.2	0	0	84	97.7
WI TOTALS	**136**	**2**	**1.5**	**1**	**0.7**	**0**	**0**	**1**	**0.7**	**0**	**0**	**132**	**97.1**
NETWORK 11 TOTALS	**669**	**13**	**1.9**	**9**	**1.3**	**1**	**0.1**	**4**	**0.6**	**1**	**0.1**	**641**	**95.8**

Educational Resources for Providers

Annual Council Meeting

Network 11 convened its Annual Council Meeting on October 15, 2010. Approximately 200 Network Council members and other facility staff attended the meeting. The meeting included sessions that addressed pertinent issues facing the ESRD community.

Joseph Messana, M.D.

Three presentations focused on aspects of the Prospective Payment System (PPS); how to maintain quality of care in a "bundling" system of reimbursement for ESRD Providers, unintended consequences, and clinical concerns. Speakers included Medical Review Committee Chair, James Brandes, M.D., Joseph Messana, M.D., and keynote speaker Tom Parker, M.D.

Additional topics addressed at the 2010 Annual Meeting included health and nutrition for people with kidney disease, best practices in vascular access, and the Renal Physicians Association (RPA) Guideline, *Shared Decision Making: Appropriate Initiation of and Withdrawal from Dialysis*.

The 2011 Annual Meeting will be held in Dearborn, MI on Friday October 14, 2011.

Annual Report

Each year in July, Network 11 submits its Annual Report to CMS as a contract deliverable. The report describes Network activities in response to CMS prescribed goals, and presents annual data tables in a CMS-prescribed format. After CMS approval, the final Report is available in Adobe PDF format, posted to the Network 11 Website. All data are from calendar year 2010 or as of December 31, 2010. For those without Internet access, the report is available on CD, by request, for a fee of $10 to cover administrative costs and shipping.

Educational Materials, Data, Information & Other Resources

In 2010, Network 11 responded to nearly 14 thousand requests for data and information from a wide variety of customers. See Tables 1 and 2. These customers included ESRD facilities and patients, patients' family members, as well as CMS, State Survey Agencies, NKF affiliates, and other Networks. Network 11 staff distributed a large variety of materials by mail and responded directly to many questions and concerns via phone or e-mail.

Table 1. Renal Network 11 Data and Information Requests, 2010

Type of Information Sent	Total
Consumer Education Grievance process information or poster, Rights & Responsibilities information or poster, Common Concerns back issues, Dialysis modality and access information, Stop Sign wallet card	2,545
Data Incidence or prevalence data counts or trend data, copies of Network 11 Annual Report or excerpts (Available on the Web)	152
Emergency Preparedness Number of Network 11 booklets sent to dialysis facilities	2,177
Fistula First Materials Number of brochures, badges, posters, staff guides, Cannulation DVDs, and Surgeon Vascular Access DVDs sent to dialysis facilities	67
HMO Status Requests	3,181
Mailing Labels (ANNA, NKF, etc) Facility personnel (electronic or hard copy)	7
Other All other requests for data or information, including: Annual Meeting Packets, CKD resources, including CKD Algorithm and wallet cards; Conditions for Coverage, Caring for Patients with Special Needs toolkit, Decreasing Dialysis Patient-Provider Conflict (DPC) toolkit, and New Provider Packets. Distributed updated Medical Review Committee Criteria to all Network 11 dialysis facilities. A copy is posted to the Network 11 Website at: www.esrdnet11.org/quality/mrc_guides.asp	1,153
Videos Access to Success (Fistula First video), Living Well on Hemodialysis, Fitness First, Home Dialysis	76
Total Requests	9,358

Table 2. Renal Network 11 Community Information and Resources, 2010

Community Information and Resources, 2010	
Category	Total Contacts
Administrative Annual Meeting Registration, Disaster Preparedness Issues, 2746 Blank Form Requests, Network Membership Agreement	194
Data Reporting Questions 2728, 2746, and 2744 Forms Compliance Electronic Reporting Issues Patient Location/Status Patient Activity Report (PAR) Patient Address Change (other than New Patient Packet corrections) Patient Census Reports	3,322
Provider Directory Regional or National Directory Assistance Facility Profile or Staffing Questions Requests for Aggregate Data	77
QI Questions CDC Guidelines Fistula First Coalition Conditions for Coverage CPM Reports Fistula First Immunization MRC Recommended Treatment Goals National Lab Data Standards of Care Transient Hemodialysis Form Unit-Specific Reports Other Clinical Information	523
Technical Assistance Individualized communication and education requiring Network staff time and expertise related to Quality Improvement, implementation of CROWNWeb, or other ESRD related topics	302
Other Assistance to Other Contractors (NWs, QIOs, etc.) Assistance to Government Agencies (CMS, SSAs, etc.) Network 11 Website – Miscellaneous Guidance	109
Total Contacts	4,527

ESRD Provider Directory

Network 11 makes continuous updates to its ESRD Provider Directory, recording over 6,000 updates in 2010. The Directory is the most frequently used item on the Network 11 Website. By routinely keeping this information up-to-date, we are ensuring that the Dialysis Facility Compare (DFC) data as current as possible.

You can access the ESRD Provider Directory on our Website as an interactive search utility. Additionally, you may download and print a copy.

Dialysis Facility Reports

The Dialysis Facility Report (DFR) is a valuable resource produced by the University of Michigan Kidney Epidemiology and Cost Center (UM KECC) and contains comparative clinical data from Medicare claims, CMS forms 2728, 2746, and 2744, and other sources and is a useful tool for evaluating patient care. The report is also used by the State Survey Agencies in setting priorities for recertification visits. The information in these reports includes the following indicators and compares facility outcomes with state, Network, and national results.

- Standardized Mortality, Hospitalization, and Transplantation Ratios
- Death rates by specific diagnosis
- Infection rates
- Anemia management, hemodialysis adequacy, and vascular access data
- Other facility characteristics that can be useful in evaluating care

In 2010, UM KECC revised its method for distributing the DFR. In former years, Networks copied and distributed the reports to Facility Administrators, Medical Directors, and Nurse Managers via US mail. Beginning with the 2010 reports, UM KECC instituted a method to allow facilities to download the reports from a secure website. In summer 2010, Network 11 distributed download instructions to 420 dialysis facilities and assisted the facilities to set up master accounts, retrieve passwords, and answer questions.

Presentations

Network 11staff frequently give presentations to dialysis facilities. In 2010, staff made the following 14 presentations to 1,695 people.

Group	Topic	Number of Attendees
Avera Healthcare	QAPI	100
WI ANNA	Conditions for Coverage	200
WI ANNA	QAPI	200
WI ANNA	Challenging Patients	200
SD SSA	Conditions for Coverage	50
FMC Managers	NW 11 update and Fistula First	75
Gunderson Units	QAPI	20
Visionex Users	QAPI	150
CRN-Rochester	Bundling	50
MN SSA	NW 11 Update	200
WI MI NKF	Bundling	150
MN ANNA	QAPI	100
Greenfield Units	QAPI	100
Greenfield Units	QAPI	100
TOTAL		1,695

Website

The Network 11 Website is located at www.esrdnet11.org. The site menu is divided into five sections: Resources, Administration, Consumer Services, Data Management, and Quality Improvement. Separate pages are dedicated to the Fistula First project, Coalitions, Patient Safety, and Data Compliance. The site employs Cascading Style Sheets and XHTML technology, and it complies with all Section 508 regulations pertaining to accessibility by disabled users.

In 2010 there were nearly 150,000 visits to pages on the Network 11 Website. Among the most frequently visited pages were:

- 2728 and 2746 FAQs
- Network 11 Annual Report
- Fistula First Tools and Resources
- Our interactive facility search utility
- Disaster Preparedness Resources
- Network 11 Annual Meeting
- Consumer Committee
- Managing Conflict
- CROWNWeb

We continue to develop the Website by updating information, enhancing user interest and readability, and improving the coding. 164 of the 1062 pages and documents on the Website have been created or revised since 1/1/2010. Some of our new content includes: information about upcoming events, Disaster Preparedness Facility Toolkit, 5 Diamond Safety Program, legislative and regulatory updates, and information related to the implementation of the electronic data collection system, CROWN Web.

Technical Assistance

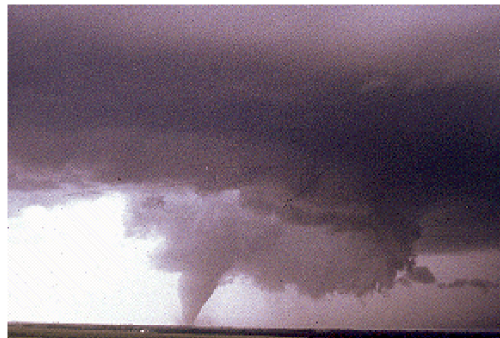
Administration

Disaster Preparedness Web page

Network 11 maintains a Web page with disaster preparedness that is among the 10 most visited pages on our Website. The page contains extensive resources for facilities and patients. The compilation of these resources may be accessed at: http://www.esrdnet11.org/resources/disaster_prep_resources.asp. In 2010, the Emergency Preparedness page of Network 11's Website was revamped to make the site more user friendly.

Disaster Coordinators Named

In November 2006 and continuing through 2010, Network 11 issued correspondence to its 400+ ESRD facilities describing the planning resources available on the new Network 11 Web page, educated them about the CMS expectations regarding disaster preparedness planning, and solicited a Disaster Coordinator and back-up designee from each facility. As required by CMS, the Disaster Coordinator information includes name, title, two telephone contacts, and e-mail address.



Quality Improvement

Network 11 is committed to assisting its facilities to improve care by providing tools, resources, and phone assistance as requested. Examples of technical assistance for dialysis facilities during 2010 include the following.

Fistula First

- Continued to provide a way for facilities to download a generic Fistula First data collection tool (with no patient-specific information) from the Network 11 Website so that disks do not need to be mailed to facilities. A user-friendly instruction manual is also provided to new facilities to assist in completion of the form.
- Distributed standard Fistula First reports to the 403 eligible facilities in Network 11. In addition, provided a supplemental report showing facilities their progress toward their annual facility-specific goal.
- Requested 182 action plans from dialysis facilities and received 100% of plans requested. Worked with these facilities by providing feedback on their QI plans and assisted them to implement their action plans and followed up by assessing for improvement.
- Updated the Fistula First page of the Network 11 Website regularly to provide the most recent information.

Medical Review Committee

- Updated the Medical Review Committee Recommended Treatment Goals and Medical Review Criteria. These were distributed to all Network 11 facilities in February 2010. A copy is posted to the Network 11 Website at: http://www.esrdnet11.org/quality/mrc_guides.asp.
- Assisted 200 independent and hospital–based dialysis facilities to complete the Elab Project collection form.
- Provided comparative lab data for approximately 400 dialysis facilities.
- Requested quality improvement plans from 100 facilities based on outcomes in anemia management, hemodialysis adequacy, or both. Provided instructions on how to complete a quality improvement plan and provided a document listing best practices for improving these clinical outcomes. Followed up with these facilities by providing feedback on the completeness of their plans.

Other QI Related Resources

- Provided copies of the Centers for Disease Control and Prevention Guidelines upon request.
- Provided assistance to facilities regarding implementation of the new Conditions for Coverage.
- Updated the Network 11 Website with links regarding FDA warnings.
- Conducted live and WebEx sessions on clinical areas (see Presentations section of this report).
- Provided a QIP evaluation form to assist facilities in developing QI action plans.
- Provided links to the Forum of ESRD Networks Medical Advisory Council toolkits on vaccination, diabetes management, catheter reduction, and medication reconciliation.
- Provided links with resources for patient safety.

Information Management

CMS Forms Compliance

CMS expects a combined rate of 90% from facilities for timeliness and complete accuracy of forms which they submit containing patient data. Network 11 assists its facilities in achieving this goal in a number of ways.

- Clear expectations from the Medical Review Committee.
- Extensive on-line Frequently Asked Questions (FAQ).
- Regular and timely feedback to facilities.
- Hands-on assistance by the Data Manager and Data staff, including, if necessary, the collection and evaluation of corrective action plans.

Electronic Data Submission – CROWN Web

The 2008 Conditions for Coverage require that facilities submit both administrative and clinical data electronically. CMS is developing a secure, Internet-based application called CROWN Web.

Since August 2009, 10 facilities in Network 11 have been using CROWN Web as part of Phase II of the implementation. CMS is currently evaluating the results of Phase II.

In May 2011, the number of Network 11 facilities using CROWNWeb was expanded to 20. CMS has announced that a Phase III will be implemented in November 2011, with a national implementation projected for February 2012.

Network 11 is assisting facilities to become aware of, learn about, and prepare to use CROWN Web by doing the following.

- Distributing information from CMS and the CROWN Web contractors to facilities via fax and e-mail.
- Maintaining a CROWN Web section of the Network 11 Website.
  - CMS documents
  - Links to important resources
  - A Frequently Asked Questions document
  - Tips for negotiating the registration process
- Presenting information about CROWN Web at the Network 11 Annual Meeting
- Making facility staff aware of training opportunities and helping them to register for training.
- Educating facility staff on the need to register as CROWN Web users, assisting staff with the registration process, and monitoring registrations.
- Handling a large volume of phone inquiries each month.

Improving Data

Introduction

Forms Processing

In 2010, Network 11 met all CMS program goals for data collection, validation, and maintenance. As the fourth largest Network in the country, we routinely process very high volumes of data as shown below.

Type of Data Processed	Numbers Processed by Network 11 in 2010
CMS 2728, Medical Evidence Form	8205 patient-specific forms
CMS 2746 Death Notification Form	5,613 patient-specific forms
CMS 2744 Annual Facility Survey Form	445 facility-specific forms counting all ESRD patients
Patient Activity Reports	4,973 facility-specific forms counting all dialysis patients
Notifications - Reconciling local and national databases	10,200 Individual reconciliations
SIMS updates	99,930 Individual updates
Facility directory updates	6,525 Individual updates
HMO or Medicare Advantage Status Requests	3,181 Individual updates

As measured by one of our Internal Quality Improvement Plans (IQPs) for Task 4.c. Collection, Completion, Validation, Submission & Maintenance of CMS ESRD Forms, the Network 11 Data Team transmits completed data within the CMS required timeframe 99.8% of the time.

Customer Service

We are commended for our data activities, and we attribute this to experience, education, and a continuous focus on data integrity. Our Data Department has a combined experience of over 45 years in data management. Three of our members are Health Information Technicians; all possess a minimum of an associate's degree. Network 11 hires and maintains professional level staff for career positions. The training of staff is intensive—taking a full year, including the participation of all Data Department members. Network 11 also has a data analyst with considerable analytical skills and institutional memory. This enables Network 11 to query and identify facility or patient record issues that arise on a daily basis, as well as to tease out trends and identify areas where Network 11 can make improvements to its process.

Furthermore, Network 11 offers its region one-on-one training and support to its constituents. Each Data Team member is assigned a territory of approximately 100 facilities. Facilities located in Minnesota, North Dakota, and South Dakota work with Sandra Schmidt. Detroit, Michigan is served by Bob Schlichenmaier, while Cheryl Dickhausen covers Greater Michigan, and Katie Klinsing works with facilities in Wisconsin. During 2010, the Data Team responded to over 3,842 data reporting questions.

Educational materials are provided to facilities via our Website and are continually updated throughout the year. These include a Data Policy & Procedures document, Frequently Asked Questions (FAQs), which cover the latest issues with CMS 2728 and 2746 forms, and a quarterly Data Department newsletter, ESRDataLINKS—with a data compliance best practices feature each year. Our 2728 FAQ page (http://www.esrdnet11.org/data/2728.asp) is among the top 5 visited on our Website, and is frequently the first site listed when "2728" is searched in Google ™.

In 2008, dialysis facilities learned that electronic data reporting would be mandatory under the new Conditions for Coverage. From that time to the present, the Network 11 Data Team has kept facilities aware of the new requirements, the development of the CMS-designated data collections system – CROWN Web, training opportunities, and the need to create user accounts. We have employed fax-blasts, mass e-mail distributions, the CROWN Web page (http://www.esrdnet11.org/data/crownweb.asp) on our Website, and have answered hundreds of phone inquiries.

Data Clean-up

Notifications Processing

Notifications are records identified by CMS as having conflicting information between the local and national databases. CMS sends ESRD Networks notification records each day. 10,200 Notification records were researched and processed by the Data Team in 2010; the team meets the 60-day deadline established by CMS for the review of each record. It is worth noting that 1,224 duplicate notifications were received from CMS—these records had the same patient and element as one previously received. Most of these multiples were contradictory.

Forms Clean-Up

Unfortunately, data submitted by facilities to Network 11 is often incomplete or inaccurate. As a result, a significant portion of data staff time is spent following up with facilities to obtain accurate and/or complete data as noted in the following table.

ESRD Forms Clean Up Network 11 2010	
Form Type	**Number and Percent of forms that required Network 11 to follow up due to error, missing data, illegible data or inaccurate data**
CMS 2728 Medical evidence form	About 1,230 or 15% of all forms filed
CMS 2746 Death notification form	About 450 0r 8% of all forms filed
Patient Activity Reports	About 895 or 18% of all forms filed
CMS 2744 Annual Facility Surveys	All 445 Facility Survey forms are balanced and reconciled

REMIS-Alerts

Another mechanism of data clean-up is REMIS-Alerts. These will be discussed in the folowing section.

Support of CMS Software and Information Systems

CROWN Web

Consolidated Renal Operations in a Web–Enabled Environment (CROWN) is a major application that supports the activities of ESRD Networks. The CROWN Web application group is comprised of: REMIS, SIMS, VISION, and QNet Exchange. A new component, CROWN Web, which will ultimately replace SIMS and VISION, has been developed and is undergoing testing. Network 11 has actively contributed to the development and testing of CROWN Web. During 2009 - 2011, the entire Data and Quality Improvement Teams along with ten volunteer dialysis facilities served in Phase II of the implementation.

QIPS

The QualityNet Identity Provisioning System (QIPS) authenticates and controls the level of access users may have to various systems, specifically to CROWN Web. Late in 2008, all members of the Network 11 Data Team qualified as QIPS System Administrators and began to enroll users at Network 11 dialysis facilities. The process has continued through 2009 into 2010, and Network 11 now has over 800 registered users. We are on target for having 100% of Network 11 facilities ready when they are phased in to use CROWN Web.

REMIS

The Renal Management Information System (REMIS) tracks both Medicare and non–Medicare ESRD patient populations. It serves as the primary mechanism to store and access information in the congressionally–mandated ESRD Program Management and Medical Information System Database. REMIS includes operational interfaces to the Medicare Beneficiary Database and SIMS. Network 11 uses REMIS-Alerts to resolve data discrepancies identified by CMS and its contractors. Due to the structure of the Alerts system, it is not possible to quantify the number of Alerts processed. However, they are routinely attended to on at least a monthly basis. All outstanding Alerts in the Generated and Referred categories are reviewed to ensure they are either resolved, referred to an appropriate Network, or actively under investigation. When Network 11 staff identify a pattern of incorrect Alerts, they bring it to the attention of the REMIS developers. Development of REMIS has been largely halted during the development of CROWN Web.

SIMS

The Standard Information Management System (SIMS) serves as a national ESRD patient registry. It is the database of record for all Medicare-certified dialysis facilities and kidney transplant centers. Network 11 provided feedback throughout the year on identified “bugs” and developed methods for troubleshooting these deficiencies. Development of SIMS has been largely halted during the development of CROWN Web.

VISION

Vital Information System to Improve Outcomes in Nephrology (VISION) is a CMS software product that dialysis facilities may use to electronically collect and transmit data when complying with federal reporting requirements (e.g., Medical Evidence and Death Notification forms). CMS has halted further roll-out of VISION to dialysis facilities, however Network 11 will continue to support 25 facilities using VISION until CROWN Web is rolled out. In 2010, Network staff downloaded 2,156 VISION-generated XML files via QualityNet Exchange. As required, a 3% validation of forms processed using VISION was conducted. The validation exercise found no forms with a missing signature.

My QualityNet (QualityNet Exchange)
QualityNet Exchange provides an interactive secure Website for ESRD Networks and Quality Improvement Organizations (QIOs) to exchange electronic patient data with their constituents. The Network 11 Data Manager serves as the administrative point of contact for creating and approving QNet users at both the Network and facility level.

QualityNet
Quality Net (QNet) refers to the entire IT infrastructure used by ESRD Networks and QIOs: their LANs, T1 lines, CROWN, the e-mail system, Remedy, as well as QualityNet Exchange. Networks are required to maintain a QNet Business Continuity Plan (QNet BCP), based on a template used by both ESRD Networks and QIOs. The document describes procedures for IT mitigation, back-up, and operational restoration, in the event that systems and/or data are lost, destroyed, or otherwise inoperable. In 2010, Network 11 reviewed this plan and submitted an updated plan, as required, in February 2011. This plan was presented to all Network staff.

New Patient Packets

All new ESRD patients receive a standard orientation packet compiled by CMS and distributed by the Network Coordinating Center (NCC) within Network 2. Packets with inaccurate addresses are returned to the Network for updating, so the rate of packet returns is one measure of data integrity. Network 11 continues to have one of the lowest rates of return in the nation. In 2010, New Patient Packets were mailed to 7,198 Network 11 consumers; 213 (2.96%) of the packets had invalid addresses which required investigation.

Facility Compliance in Data Reporting

CMS has established performance requirements for ESRD service providers to meet when submitting Medical Evidence (2728) and Death Notification (2746) forms. A rate of 90% or better for data timeliness and accuracy is expected of facilities. As required by CMS, Network 11 issues CMS Forms Compliance Reports to all units, twice each year. These reports detail facility compliance results. CMS defines noncompliance as an annual average compliance rate of less than 90% for timeliness and completeness/accuracy.

As prescribed by CMS, facilities not achieving compliance at the six-month mark are asked to review and modify their procedures in order to achieve 90% by the year-end. Facilities that do not achieve annual compliance may be asked to submit a quality improvement plan (QIP), and a list of facilities not reaching compliance is submitted to the Network 11 Project Officer. In addition to receiving their compliance reports at contractually prescribed intervals, facilities may request updated reports to track their progress at any time of the year. We are pleased to report that many more facilities are taking advantage of this opportunity.

Overall, the number of late or erroneous forms has steadily declined, and the number of facilities achieving the 90% rate has steadily increased over the past 6 years. See figures 1 & 2.

Improving Data Compliance Rates

In December 2005, the Medical Review and Executive Committees approved comprehensive data compliance guidelines. These guidelines are mailed to all facilities annually in January, along with the Network 11 Medical Review Committee Treatment Goals. The document is also posted to our Website at: http://www.esrdnet11.org/assets/pdf/data_team/MRC_compliance_guidlines.pdf.

Figure 1. Forms Compliance by Network 11 Facilities, 2005-2010

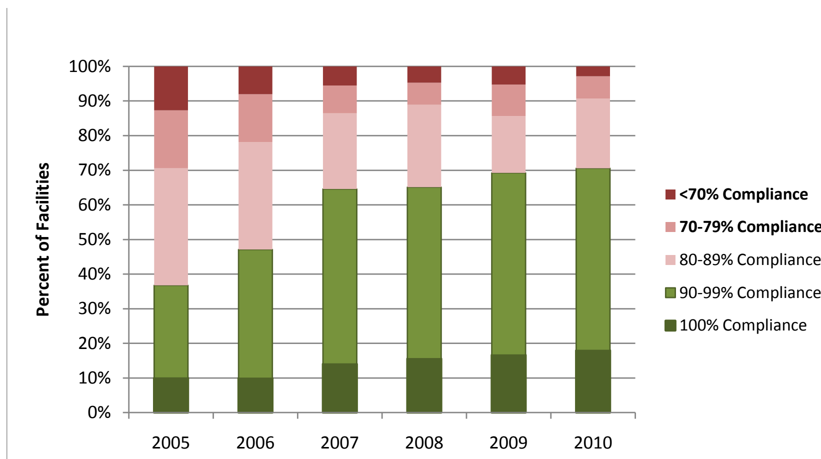
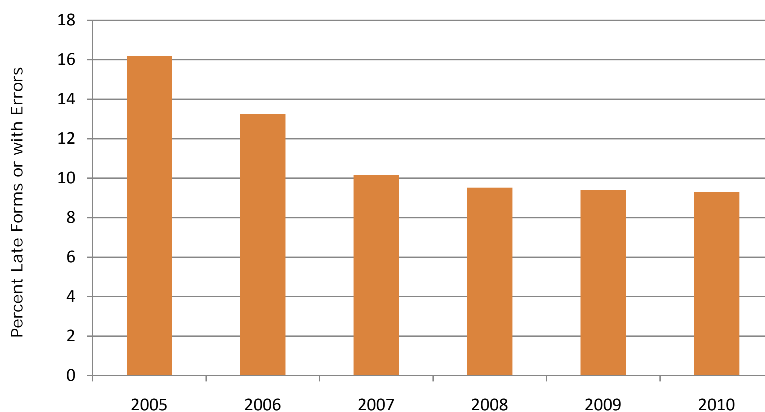


Figure 2. Percent Late Forms or Forms With Errors, Network 11 Facilities, 2005-2010



To provide more timely feedback to facilities, Network 11 strives to exceed CMS contract requirements by issuing reports one month after the six and twelve-month reporting time periods. For example, CMS requires Networks to issue six-month compliance reports (reflecting performance for January–June) by mid-October. Network 11 attempts to issue them in late July or early August. By providing more current information to facilities, we hope to provide facilities with a better opportunity to affect change and improve compliance rates by the time annual reports are issued.

Network 11 has always attempted to take a proactive approach of encouragement. Some examples include: at the 2010 Network 11 Annual Meeting, posters were displayed listing compliant facilities as well as facilities that had achieved a 100% data compliance rating. Furthermore, Network 11 is committed to sharing best practices among facilities through its newsletters and Website.

Partnerships and Cooperative Activities

Upper Midwest Fistula First Coalition

Background

In 2005, Network 11 invited members of the renal community to convene a coalition that focused on improving arteriovenous fistula (AVF) prevalence rates within Network 11's five states and to address issues related to early identification and referral of chronic kidney disease patients. Providers, state survey agencies (SSA), quality improvement organizations (QIO), and Network 11 met August 12, 2005 to start the Upper Midwest Fistula First Coalition. During that initial meeting, three workgroups formed that would target the improvement of AVF prevalence through the continuum of care. The Early Referral workgroup targeted efforts toward the primary care physicians, the CKD Management workgroup targeted efforts toward the nephrology community, and the ESRD workgroup targeted facilities caring for patients on dialysis. The mission of the coalition was written and continues in 2010:

To improve care received by chronic kidney disease (CKD) patients by identifying and implementing system-level changes that will lead to an increase in patients receiving hemodialysis via a native AV fistula.

Figure 1. Members and organizations of The Upper Midwest Fistula First Coalition

Member Name	Organization
Mary Absolon	Minnesota Department of Health
Ruth Agrusa	Consumer
Teverlyn Allen	Wisconsin Department of Health
Debbie Bowe	Kidney Institute
James Brandes	Midwest Nephrology
Diane Carlson	Network 11
Regina Fox	DaVita
Jan Deane	Network 11
Michelle Doro	Wisconsin Department of Health
Ione Eckroth	Medcenter One
Leslie Ford LePard	Greenfield Health Systems
Jill Harris	Centra Care Dialysis
Cindy Huber	NKF Wisconsin
Tim Jackan	Prairie Lakes Healthcare
Nancy Johnson	Great Lakes/Regional Dialysis
Michelle Krueger	WI Dialysis, Inc.
Bill Lund, PA	Centra Care Dialysis
Marge Meeker	Minnesota Department of Health
Xinliu Meyer	WI Dialysis, Inc.
Peg Myhre	Gundersen Lutheran
Renae Nelson	Network 11
Gail Nylin	DaVita
Gina Prebeck	Fresenius Medical Care
Charles Rice	Consumer
Victor Rozas, MD	Great Lakes Renal Network
David Shepherd	Greenfield Health Systems
Mary Sinnen	Hospital Provider
Chris Singer	Network 11
Martha Stewart	WI Dialysis, Inc.
Christa Wagner	Centra Care Dialysis
Bridget Weidner	North Dakota Department of Health
Brad Wick	Mayo Health Systems

Activities

The Coalition is very dynamic in its quest to improve care for patients in the Upper Midwest region. In 2008, the Coalition conducted its annual face-to-face meeting and reorganized 3 existing workgroups into 2. The aim was to focus more on the transition from CKD to ESRD. At the 2009 Annual Meeting, the Coalition decided to merge into a single workgroup to reduce overlap of projects and pull in all available resources to move project ahead. The workgroup continued its main focus in 2010 with the following priorities:

Patient Resistance: In 2009, the workgroup developed a patient guide, Fistula or Catheter; the Patient's Perspective, which incorporated the patient perspectives to educate patients on the importance of placement of an

AVF. In 2010, the workgroup augmented the patient guide by developing a resource to educate staff on patient resistance. The resource developed was a WebEx presentation, given to 150 facilities in March 2011, entitled Overcoming Resistance. See Figure 2.

- **Vessel Preservation:** The workgroup focused on developing tools and resources that would educate both patients and staff on how to assess a fistula and how to recognize complications. A poster was developed to hang at each dialysis station that guides both patients and staff how to recognize warning signs of complications.
  See Figure 3.
  In addition, a Vascualr Access Assessment Checklist was created, suitable for use in indiviual patient charts. Network 11 sent both resources to dialysis facilities in February 2011.

Figure 2. *Overcoming Resistance*

Figure 3. AVF Assessment Poster

For more information on the Upper Midwest Fistula First Coalition, please visit www.esrdnet11.org/visit/fistulafirst/coalition.asp.

Fistula First Break Through Initiative (FFBTI)

In addition to attending the Fistula First Break Through Initiative (FFBTI) monthly calls, Network 11 shared resources we developed with the national FFBTI. Examples of such resources shared in 2010 include a Vascular Access Assessment Poster for use by patients and staff at each dialysis station and a Vascular Access Assessment Checklist, suitable for use in individual patient medical records. Chris Singer continued to serve on the FFBTI Data Committee. Diane Carlson, Jan Deane, and Kristen Ward attended the Fistula First presentation at the QualityNet Conference in December 2010.

Centers for Medicare & Medicaid Services (CMS)

CMS awarded a 21-month contract to Network 11 for the period September 30, 2010-June 30, 2012. Through this contract relationship, Network 11 has many cooperative activities with CMS, which are summarized in this report, including:

- Fistula First
- Elab Project
- ESRD patient registry and provider directory
- CROWN Web development
- Dialysis Facility Compare
- Patient services
- Emergency Preparedness and Response
- Business Continuity Plans

Network 11 has actively participated in the annual QualityNet meetings, monthly conference calls, and quarterly calls with CMS Regional Office and Central Office. Network 11 also participated in the conference hosted by the Kansas and Chicago Regional Offices of CMS on coordination across transitions of care.

Network 2, Network Coordinating Center (NCC), and IPRO North Carolina Office

Network 2 has the Network Coordinating Center contract with CMS to maintain the Fistula First dashboard, to receive LDO data for the National Elab Project, to compile the national Annual Report on behalf of all Networks, to distribute patient education materials to newly diagnosed ESRD patients, and to perform other projects. To support these national efforts, Network 11 has worked on the following.

- **Fistula First:** Network 11 routinely submits data from independent dialysis facilities for inclusion in the Fistula First dashboard and updates the dashboard as needed.
- **National Elab Project:** Large Dialysis Organizations (LDOs) submit lab data to the North Carolina Office of IPRO (Island Peer Review Organization of New York). Using a standard format, independent dialysis facilities also submit lab data to their respective Network. Network 11 has worked for several years to merge the LDO and independent dialysis unit lab data into a national database of lab data for nearly all dialysis units and nearly all dialysis patients. (See other sections of this report for more details.) Network 11 prepared the databases and generated the comparative facility-specific Elab Reports for each participating ESRD Network. For Q4 2009 and Q4 2010, all 18 Networks participated.

- **National Annual Report:** After Project Officer approval, Network 11 submitted its 2009 Annual Report for use by the NCC as they compiled and prepared the national report for all Networks. Network 11 also assisted the NCC by completing their 2008 and 2009 Annual Report templates.
- **New patient education:** Network 11 works with Network 2 on assuring that the new patient education packets are distributed correctly.

Network 7 and CROWNWeb Contractors, such as Edaptive

Network 7 and other contractors, such as Edaptive, had contracts to develop CROWN Web, support the Clinical Performance Measures Project, and other information technology responsibilities for the ESRD Program. Network 11 has volunteered in several ways to support development of CROWN Web. See other sections of this report for details on testing, training, and data access.

ESRD Networks

Network 11 worked with other Networks in the following ways.

- Worked with all 18 Networks to produce facility-specific reports for the Elab Project.
- Worked with Network 8 as back up to one another in event of emergency.
- Participated in national meetings of Executive Directors, Data Managers, Patient Service Coordinators, and Quality Improvement Directors to exchange ideas and to share Network 11 resources.
- Collaborated on a Disparity Project with Networks 1, 5, 6, 9, 10, 11, and 14. The Disparity Project aimed to analyze patient and facility characteristics that could be associated with payment deductions under the Quality Incentive Program. Preliminary multivariate analyses indicate that no patient characteristics were statistically significant, however, small dialysis units were found to have a statistically significantly higher risk of payment deductions.
- Collaborated on a Transplant Consortia Project with Networks 4, 9, 10, 11, and 12. Plans included presenting three webinars on various aspects of the kidney transplantation and donation process. Webinars will be convened in 2011.
- Joined the 5-Diamond Safety Project, led by Networks 1 and 5. The project will be launched in Network 11 in Spring 2011.

Forum of ESRD Networks

The Forum of ESRD Networks is a nonprofit organization (501c3) that advocates and coordinates activities of mutual interest to its membership of ESRD Networks. Activities in 2010 included the following.

- Developed and distributed Quality Assessment and Performance Improvement tool kits on medication reconciliation, catheter reduction, immunization, and diabetes management.
- Submitted comments to CMS on Fistula First Data Reliability.
- Convened “Creating a Culture of Quality”, a conference attended by CMS, ESRD Networks, ESRD providers, and other renal related organizations.
- Submitted comments to CMS regarding the Quality Incentive Program (QIP).
- Requested that CMS review the classification of patients as “involuntarily discharged” when their facility is closed. AAKP, the NKF, and RSN supported this letter from the Forum, and we were pleased when CMS agreed to implement this position.

- Endorsed and distributed the *Shared Decision Making in the Appropriate Initiation of and Withdrawal from Dialysis* produced by the Renal Physicians Association.
- Worked with nearly all Networks to compile the experience with CROWNWeb Phase II and associated CROWNWeb experiences. A CROWNWeb Summary Report was compiled and submitted to CMS on behalf of all Networks

Other Related Organizations

In 2010, Network 11:

- Worked with various chapters of American Nephrology Nurses Association.
- Worked with National Kidney Foundation affiliates on data requests, chronic kidney disease education projects, and Kidney Evaluation and Education Program (KEEP) screenings.
- Assisted chapters of Council of Nephrology Social Workers.
- Collaborated with large dialysis organizations on educational events such as cannulation training and data training.
- Assisted ESRD facilities, State Health Departments, and utility companies with emergency preparedness.
- Worked with the Centers for Disease Control on topics such as immunizations.
- Worked with the Network Coordinating Center to distribute new patient packets.
- Distributed Dialysis Facility Reports prepared by Arbor Research using the new Web based system.

State Survey Agencies

In 2010, Network 11 hosted quarterly calls with all five State Survey Agencies (SSA). The calls allow the opportunity for sharing information between the SSAs and Network 11 and among the SSAs themselves. It has been particularly helpful to address topics such as common citations, involuntary discharge, and conditions of coverage. Network 11 works closely with its State Survey Agencies in a variety of other ways including:

- Collaborated to receive and resolve patient concerns.
- Collaborated on quality of care concerns.
- Acted as a clinical resource to assist the SSAs when reviewing facilities.
- Several SSA representatives are contributing members of the Upper Midwest Fistula First Coalition.
- Network 11 assisted with SSA training sessions.
- As the Forum representative to the CMS Survey and Certifications, Network 11 distributed updates to the Measurement Assessment Tool at the request of CMS.

Quality Improvement Organizations (QIOs)

Network 11 has partnerships with the five QIOs in Network 11's region, and we periodically work with other QIOs as well. Specifically:

- All five QIOs in the Network 11 region are invited to join Network 11's Upper Midwest Fistula First Coalition, which also has an emphasis on Chronic Kidney Disease.
- Network 11 routinely participates in the Community Outreach meetings hosted by StratisHealth.
- Discussed opportunities for collaboration with QIOs that also attended the Care Coordination conference hosted by the Kansas and Chicago Regional Offices of CMS.
- The Utah QIO requested permission to use Network 11's Chronic Kidney Disease algorithms as part of a CKD project that they have submitted to the National Institutes for Health. Network 11 granted permission and offered to assist as needed.
- QIOs that received CKD contracts from CMS requested resources from Network 11. Resources included Network 11's CKD algorithms and our Your Access to Success DVD.

Patient Grievances / Consumer Services

Consumer Services

Network 11 receives input from its dialysis and transplant consumers in several ways. The Consumer Committee is comprised of 13 ESRD (dialysis and transplant) consumers who work with Network staff in the following areas.

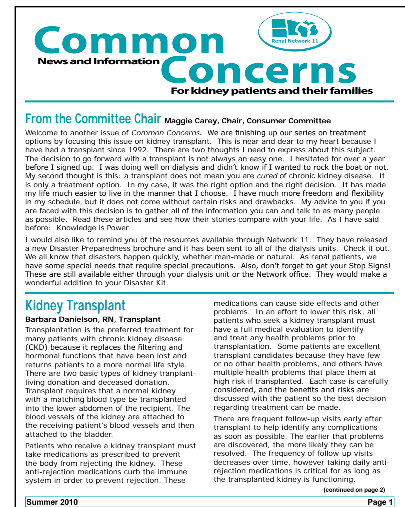
- Publishing a patient-centered newsletter, Common Concerns
- Developing and helping to implement special projects
- Serving on the Executive Committee and the Medical Review Committee

More information regarding the Consumer Committee activities can be found in the Committees section of this report.

The Patient Services Coordinator (PSC), serves as a resource to ESRD patients by responding to patient concerns regarding quality of care, access to care, and rehabilitation. In addition, the PSC assists dialysis facilities and transplant centers with difficult patient situations and other patient-related concerns.

Common Concerns

In collaboration with the Consumer Committee, Network 11 coordinates the publication of a patient newsletter, Common Concerns. Two issues of Common Concerns were published in 2010. One issue focused on Transplant and the second issue focused on Infection Control. Each issue was mailed to about 42,000 patients' homes in Network 11. Copies were made available to facilities both electronically and on the Network 11 Website.



Common Concerns

Renal Network 11

News and Information

For kidney patients and their families

From the Committee Chair Maggie Carey, Chair, Consumer Committee

Welcome to another issue of *Common Concerns*. We are finishing up our series on treatment options by focusing this issue on kidney transplant. This is near and dear to my heart because I have had a transplant since 1992. There are two thoughts I need to express about this subject. The decision to go forward with a transplant is not always an easy one. I hesitated for over a year before I signed up. I was doing well on dialysis and didn't know if I wanted to rock the boat or not. My second thought is this: a transplant does not mean you are *cured* of chronic kidney disease. It is only a treatment option. In my case, it was the right option and the right decision. It has made my life much easier to live in the manner that I choose. I have much more freedom and flexibility in my schedule, but it does not come without certain risks and drawbacks. My advice to you if you are faced with this decision is to gather all of the information you can and talk to as many people as possible. Read these articles and see how their stories compare with your life. As I have said before: Knowledge is Power.

I would also like to remind you of the resources available through Network 11. They have released a new Disaster Preparedness brochure and it has been sent to all of the dialysis units. Check it out. We all know that disasters happen quickly, whether man-made or natural. As renal patients, we have some special needs that require special precautions. Also, don't forget to get your Stop Signs! These are still available either through your dialysis unit or the Network office. They would make a wonderful addition to your Disaster Kit.

Kidney Transplant

Barbara Danielson, RN, Transplant

Transplantation is the preferred treatment for many patients with chronic kidney disease (CKD) because it replaces the filtering and hormonal functions that have been lost and returns patients to a more normal life style. There are two basic types of kidney tranplant– living donation and deceased donation. Transplant requires that a normal kidney with a matching blood type be transplanted into the lower abdomen of the recipient. The blood vessels of the kidney are attached to the receiving patient's blood vessels and then attached to the bladder.

Patients who receive a kidney transplant must take medications as prescribed to prevent the body from rejecting the kidney. These anti-rejection medications curb the immune system in order to prevent rejection. These medications can cause side effects and other problems. In an effort to lower this risk, all patients who seek a kidney transplant must have a full medical evaluation to identify and treat any health problems prior to transplantation. Some patients are excellent transplant candidates because they have few or no other health problems, and others have multiple health problems that place them at high risk if transplanted. Each case is carefully considered, and the benefits and risks are discussed with the patient so the best decision regarding treatment can be made.

There are frequent follow-up visits early after transplant to help identify any complications as soon as possible. The earlier that problems are discovered, the more likely they can be resolved. The frequency of follow-up visits decreases over time, however taking daily anti-rejection medications is critical for as long as the transplanted kidney is functioning.

(continued on page 2)

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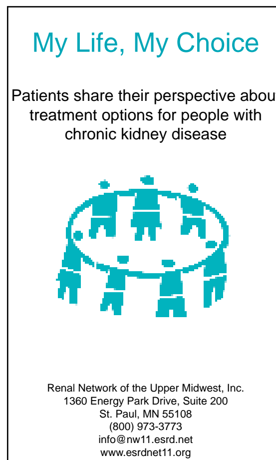
Summer 2010 Common Concerns



My Life, My Choice

Patients share their perspective about treatment options for people with chronic kidney disease

Renal Network of the Upper Midwest, Inc.
1360 Energy Park Drive, Suite 200
St. Paul, MN 55108
(800) 973-3773
info@nw11.esrd.net
www.esrdnet11.org

My Life, My Choice,
Patient Options Booklet

My Life, My Choice

In 2010, the Network 11 Consumer Committee identified a need for a resource to assist patients in deciding which modality is best for them and suits their lifestyle. The Consumer Committee developed a booklet that not only explains ESRD treatment options, but also shares the experiences from people with kidney disease who have chosen that particular treatment modality.The booklet was distributed to all Network 11 dialysis units and transplant facilities.

Contacts and Grievances

Patient and Facility Concerns

Network 11 staff works proactively whenever possible to address patient concerns before they become grievances. Network 11 also receives calls from facility staff concerning difficult patient situations. Network staff assist facility staff in developing and implementing strategies to prevent the escalation into more serious situations that might lead to involuntary discharge. Much of this assistance is working with nurses, social workers, and administrators to examine, understand, and provide resources for managing difficult patient situations.

In 2010, 476 concerns were opened, addressed, and closed. The majority of the calls (58.8%) came from facility staff and 28.1% of the calls came from either patients or patient's family members. There were no formal grievances in 2010. Figures 1-3 show a more complete breakdown of contacts and concern types. Two interesting highlights were as follows.

- Increased contacts about reimbursement.
- Increased contacts about staff related issues; further investigation did not suggest need for action.

Figure 1. Trends in Facility Contacts in Network 11, by Reason for Contact, 2006-2010

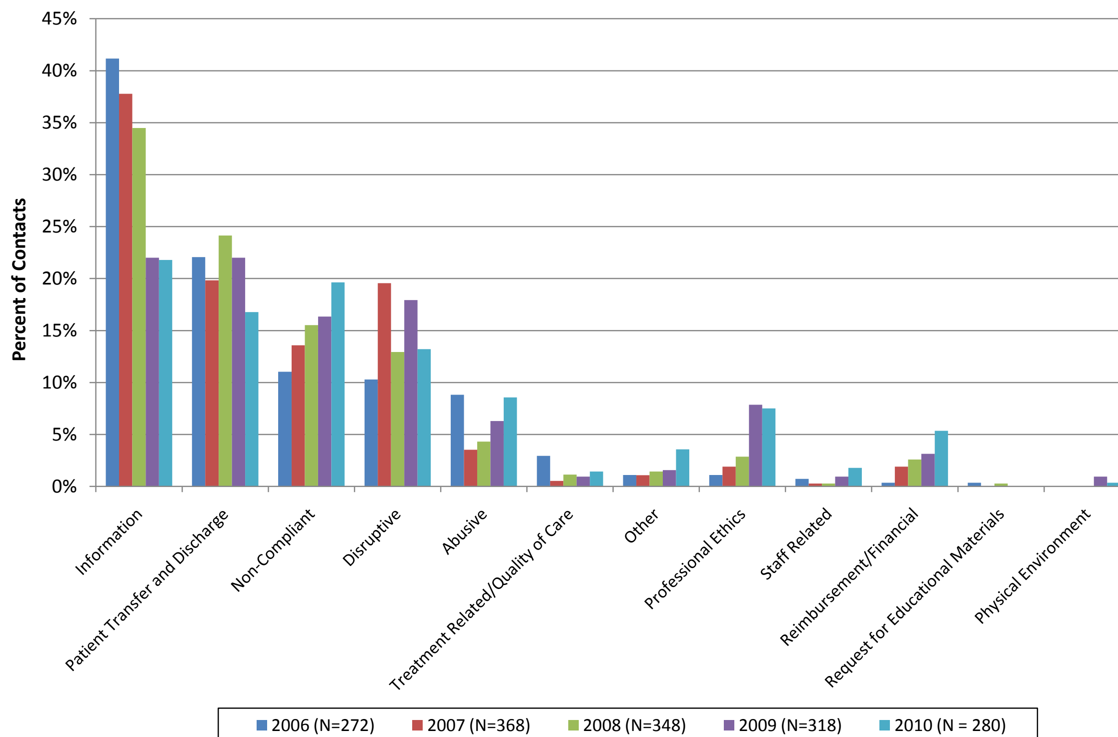


Figure 2. Trends in Patient Contacts in Network 11, by Reason for Contact, 2006-2010

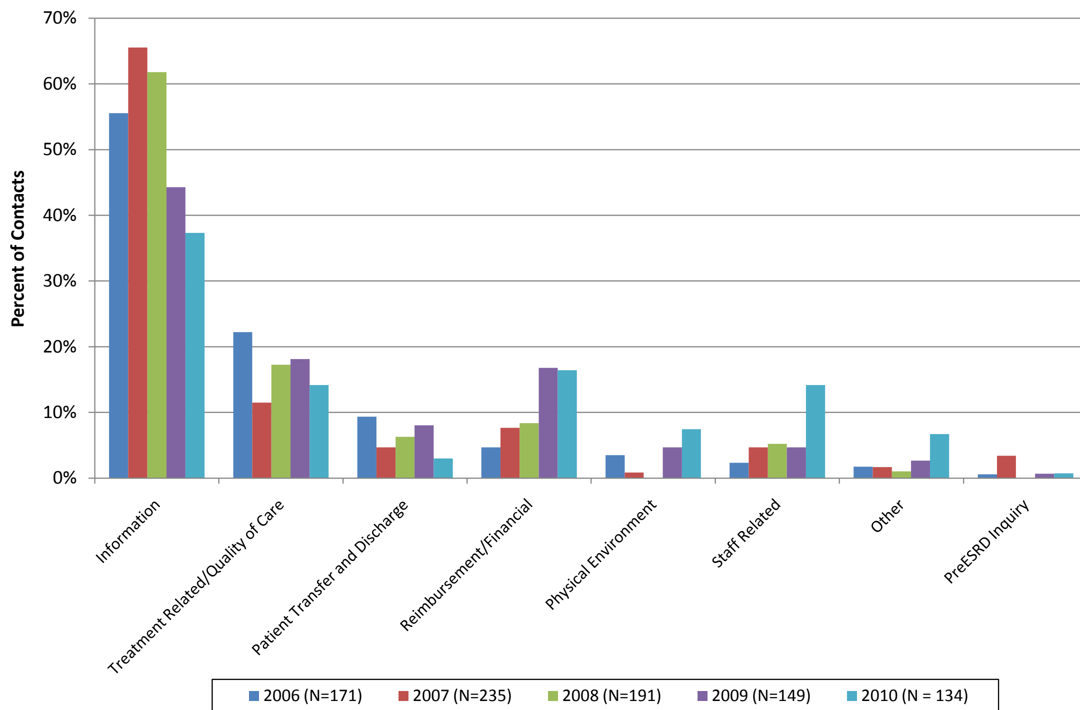
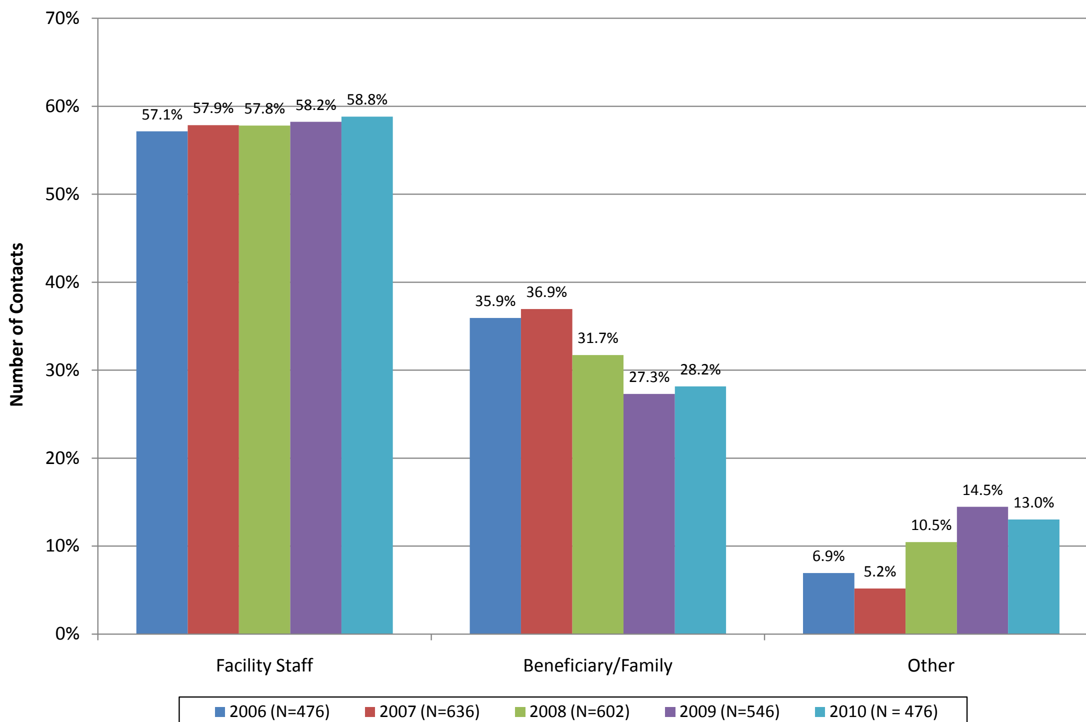


Figure 3. Trends in All Contacts in Network 11, by Contact Type, 2006-2010



Involuntary Discharge

Network 11 remains committed to assisting facilities to resolve conflict and prevent patients from being involuntarily discharged from the facility, particularly for non-adherence. Network 11 encourages facility staff to call and discuss patient concern issues before they escalate to the point of discharge, and to use the Decreasing Dialysis Patient Provider (DPC) tools to assist in managing conflict. Not all involuntary discharges can be prevented, however. With this in mind, Network 11 continues to track and analyze involuntary discharge trends. In 2010, there were 20 patients involuntarily discharged from Network 11 facilities. Figure 4 demonstrates the rate of discharges trended over time (discharges/1000 patients). The number of discharges decreased by 50% in 2010, and the overall rate is the lowest ever for Network 11.

Figure 4. Involuntary Discharge Trends in Network 11, 2004-2010

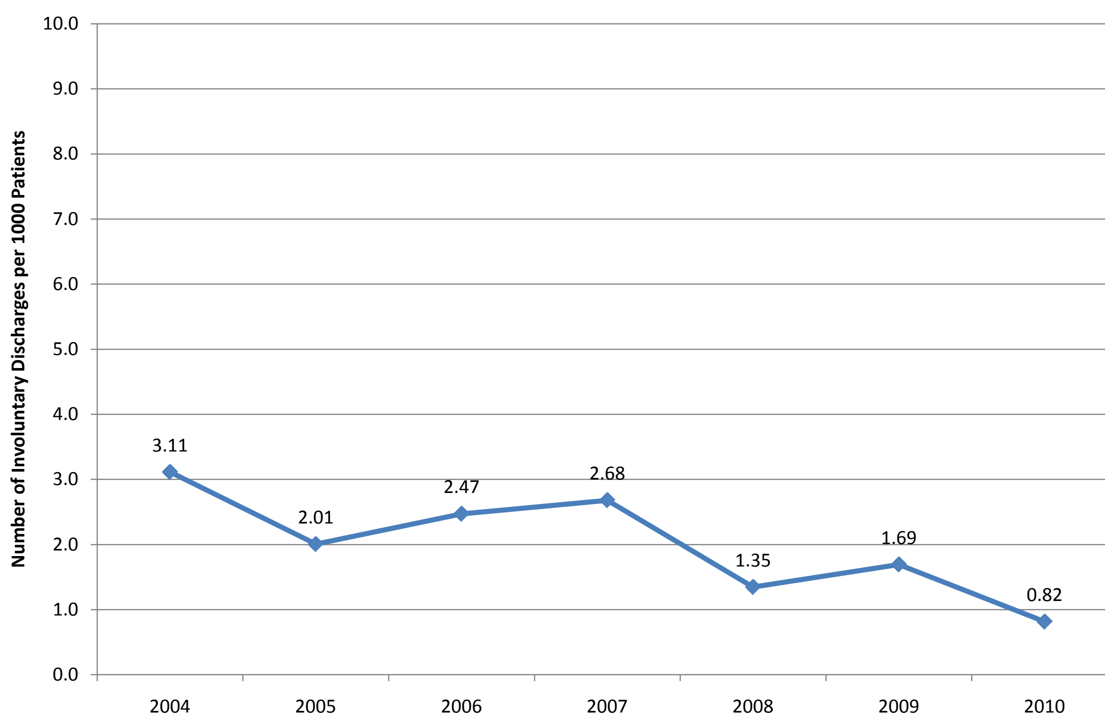
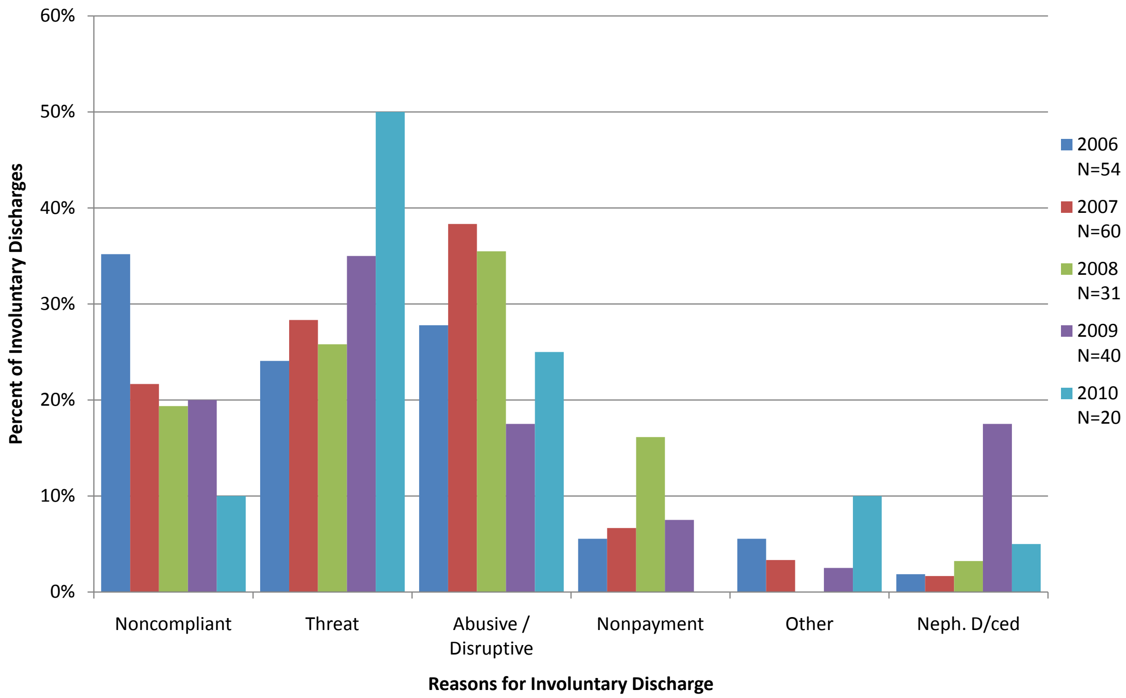


Figure 5 shows the 5-year trending of involuntary discharges by reason. The Network 11 Medical Review Committee and the Conditions for Coverage do not consider nonadherence with treatment as a reason for discharge.

Figure 5 also demonstrates that discharges for nonadherence to treatment have decreased over time. There were only two patient discharges for nonadherance in 2010; the lowest in Network 11 history. Network 11 appreciates the strategies and interventions used by its dialysis facilities to care for patients who are nonadherent with treatment.

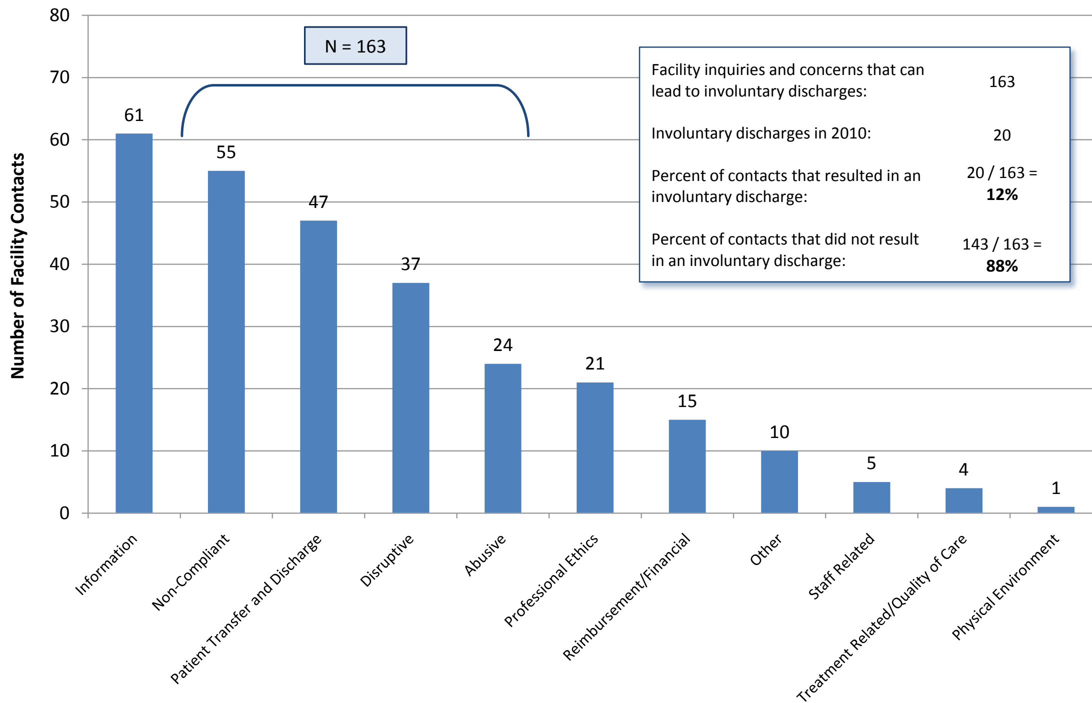
In 2009, there was a dramatic increase in patients being discharged by physician. Network 11 distributed letters to every facility clarifying that this is also considered an involuntary discharge. In 2010, this category has decreased significantly.

Figure 5. Involuntary Discharge Trends in Network 11, by Reason for Discharge, 2006-2010



Network 11 encourages dialysis facility staff to contact the Network office when faced with difficult patient situations. While not all discharges can be prevented, Network staff can discuss the issues, offer suggestions of potential strategies, and provide resources to assist the facility to prevent the situation from escalating to the point of discharge. The focus of interventions is to prevent involuntary discharges whenever possible. Reasons for facility contacts to Network 11 are displayed in Figure 6. Of 163 calls from facilities for reasons that could potentially lead to involuntary discharge, only 20 patients (12%) were eventually discharged. In 88% of the cases, the contact did not lead to discharge. It is encouraging to note that facility staff are able to employ strategies that lead to the prevention of involuntary discharge.

Figure 6. Areas of Concern of Facility Contacts in Network 11 for 2010, n=280



Vocational Rehabilitation

Annually, as part of the Annual Facility Survey, Network 11 collects data from each dialysis facility regarding vocational rehabilitation activities (see 2010 Vocational Rehabilitation Tables in the data tables section). The following data are collected for patients dialyzing in each facility.

- Number of patients between the ages of 18-54 who are employed full or part-time
- Number of patients between the ages of 18-54 who are in school full or part-time
- Number of patients between the ages of 18-54 who are receiving vocational rehabilitation services
- Number of dialysis facilities that offer a dialysis shift after 5:00 pm.

The following table summarizes Network 11 Vocational Rehabilitation Data from 2002-2010. These data show that the percent of patients in each category has remained relatively stable over the past several years. Network 11 will be continuing to review the data to determine regional variation and identify best practices.

Year	% of Patients Receiving Vocational Rehabilitation	% of Patients Employed, FT or PT	% of Patients in School, FT or PT	Total % of Patients Employed or in School	Number of Facilities with a Shift Starting After 5:00 PM	% of Facilities with a Shift Starting After 5:00 PM
2002	2.70%	21.70%	3.30%	25.00%	55	18%
2003	2.70%	22.80%	2.60%	23.30%	60	19%
2004	2.90%	20.70%	2.60%	23.30%	66	19%
2005	2.39%	19.91%	2.70%	22.61%	65	18%
2006	3.07%	20.87%	2.74%	23.61%	78	20%
2007	2.09%	19.81%	2.67%	22.47%	84	22%
2008	1.76%	20.18%	2.97%	23.15%	95	24%
2009	1.60%	18.89%	3.60%	22.49%	92	21%
2010	1.73%	19.32%	3.65%	22.97%	90	21%

Sanction Recommendations

Sanctions or Alternative Sanction Referrals

Definitions

Sanctions refer to the process where the Centers for Medicare & Medicaid Services (CMS) may terminate a facility's Medicare coverage.

Alternative sanctions refer to the process where CMS may deny or reduce Medicare payment for ESRD services.

Federal Regulations

Federal regulations (CFR42 405.2180 – 2184, CFR42 405.2134 and 494.180i) address the circumstances that may result in sanctions or alternative sanctions. CMS is authorized to impose sanctions or alternative sanctions if a facility fails to meet one or more Medicare Conditions for Coverage or fails to participate in Network activities and pursue Network goals.

CMS Contract Requirements

The CMS contract with each ESRD Network specifies that the Networks' responsibilities for sanction or alternative sanction recommendations and referrals include recommending to CMS sanctions or alternative sanctions for facilities that consistently fail to comply with Network goals and/or are not providing appropriate medical care.

Network 11's Policies

Network 11's Medical Review Committee Recommended Treatment Guidelines, which are updated annually, specify review criteria and review processes, which include recommendation of sanctions or alternative sanctions. Network 11's written policy for sanction or alternative sanction recommendations incorporates the federal regulations and outlines procedures for addressing any potential or perceived conflict of interest within the Committees making the recommendations.

ESRD Facility-Specific Performance Measures Monitored

- **For dialysis facilities**- Lab data, Standardized Mortality Ratios, Dialysis Facility Reports, immunization data, and AVF rates are monitored for patterns in outcomes of care.
- **For transplant centers**- First-year outcomes and Center-Specific Reports are monitored for outcomes.
- **For ESRD facilities**- Other patterns monitored include patient concerns, involuntary patient discharges, data compliance, and referrals from other agencies such as State Survey Agencies.

2010 Status Report

Network 11 did not refer or recommend any sanctions or alternative sanctions for any dialysis facilities or transplant centers in the current contract year.

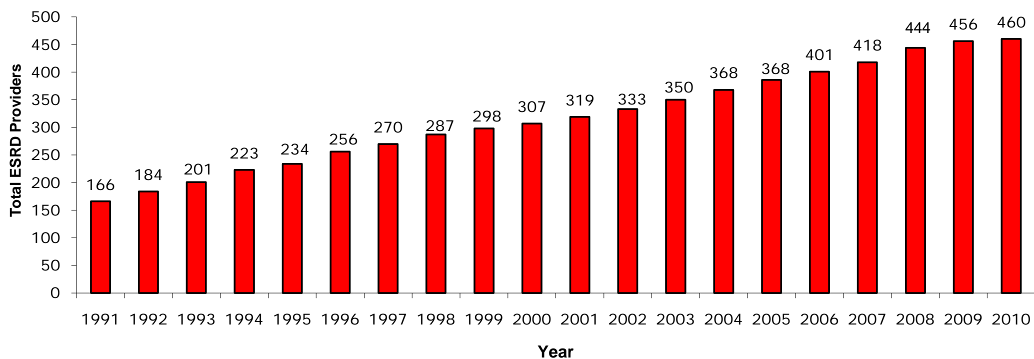
Recommendations for Additional Facilities

Recommendations for Additional Facilities or Additional Services

Growth in ESRD Providers

Network 11 is among the fastest growing ESRD Network regions in the country. In the past five years, the average number of new facilities opening per year in Network 11 has been 19. Since 1990 there has been a 194% increase in the number of ESRD facilities. See figure 1.

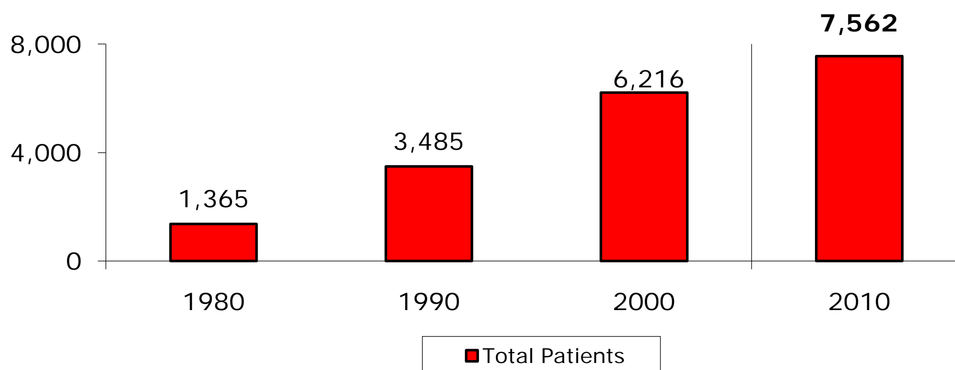
Figure 1. Network 11 ESRD Providers 1990–2010



Growth in the ESRD Incidence Population

Since 1980, Network 11 experienced a 456% increase in the number of new ESRD patients served each year and 117% since 1990. See figure 2.

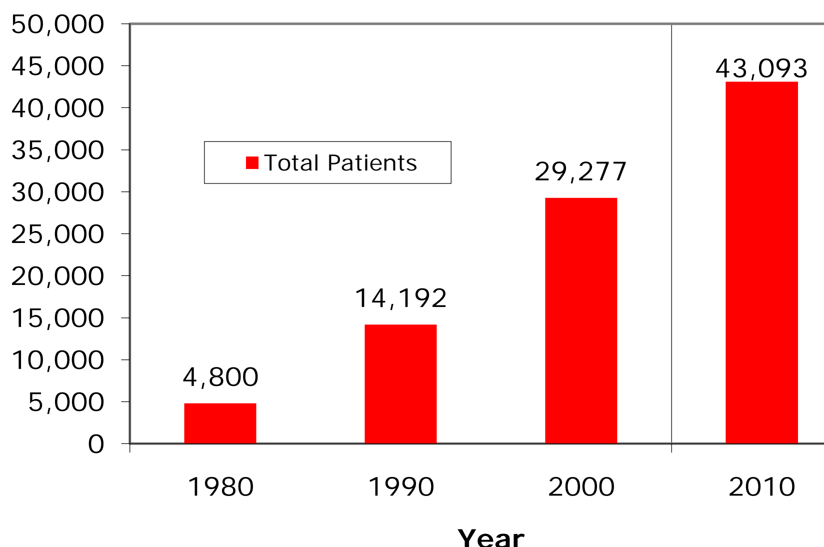
Figure 2. Network 11 ESRD Patient Incidence (Dialysis & Transplant)—1980, 1990, 2000, and 2010



Growth in the ESRD Prevalence Population

Network 11 had an increase of 195% in the number of total ESRD patients served in this region since 1990. See Figure 3.

Figure 3. Network 11 ESRD Patient Prevalence (Dialysis & Transplant)—1980, 1990, 2000, and 2010



Network 11 Assistance

There is consistent and dramatic growth among ESRD providers and patients in Network 11 (see Figures 1–3). In response, Network 11 frequently receives requests from potential ESRD providers for health care planning information, such as incidence and prevalence data. Also, Web analytics demonstrate that users are frequently downloading incidence, prevalence, and zip code statistics from Network 11's Website.

With the continuous new demands for service in Network 11 each year, we accommodate this increase and meet the proliferating needs of providers and patients with our available resources.

Recommendations

- In 2010, Network 11 continued to work with two patients, a hospital, two Regional Offices of CMS, Central Office of CMS, and the State Survey Agencies regarding the Special Purpose Dialysis Facility application process.
- Also, because there are situations where patients are denied access to care, such as involuntarily discharged dialysis patients, Network 11 recommends that CMS adopt a special needs composite rate to assist ESRD facilities that accept care for such special needs patients. Network 11 also recommends that in-patient dialysis units be allowed to accept special ESRD patients and still be reimbursed comparable to the composite rate.