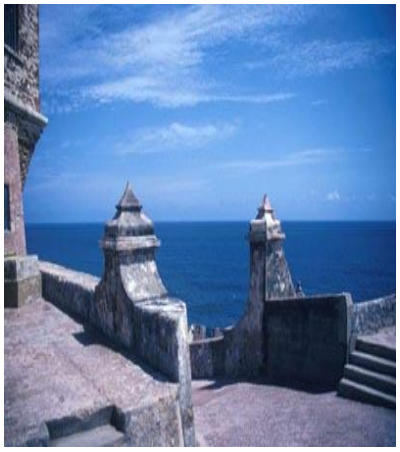
Quality Insights
Renal Network Three

2012 Annual Report

ESRD Network 3
Contract Number: 500-2010-NW003C

New Jersey **Puerto Rico** **U.S. Virgin Islands**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June 28, 2013

I. Preface

Quality Insights Renal Network 3 is pleased to present its 2012 ESRD Annual Report. 2012 was an exciting and challenging year for QIRN3. We continued working to decrease the number of patients who use catheters as their primary access and reduce the rate of healthcare acquired infections in dialysis providers. We also served as an independent investigatory resource for patients who have concerns, complaints, or grievances about their dialysis provider.

Thanks to the cooperation and good work from our facilities and partners, we saw many clinical care and quality improvement successes. This includes continued progress toward the CMS goal of 66% of patients using an arteriovenous fistula (AVF) for their dialysis treatment

At the direction of our Medical Review Board and Board of Directors, we have been working on reducing the inappropriate use of catheters since 2005. This important initiative remained one of the projects that we continued to focus on during 2012. We particularly emphasized on reducing catheters in use for more than 90 days.

We continued working with the Centers for Disease Control and Prevention (CDC) in 2012 to reduce the incidence of Healthcare Acquired Infections (HAI) in outpatient dialysis providers. By the end of 2012, all dialysis providers in Network 3 had registered and reported 3-12 months of data to the CDC/NHSN data system. In Puerto Rico, we developed a Learning and Action Network (LAN) with stakeholders, partners, and subject matter experts to address high infection rates in dialysis units in this area.

We hope you find this year's annual report useful and look forward to hearing about any potential improvements or partnership opportunities you have to share. We are also looking forward to working with you, our valued partners, in the coming year to improve the health of the people we serve.

John C. Wiesendanger
CEO
WVMI & Quality Insights

The mission of Quality Insights Renal Network 3 is to provide the professional framework within which the provision of quality care to consumers of end-stage renal disease services can be maximized.

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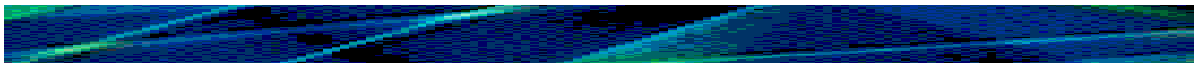


II. Introduction

Quality Insights Renal Network 3 (QIRN3) is one of 18 End Stage Renal Disease (ESRD) Network Organizations in the country to participate in the ESRD Network Organization Program as a contractor to the Centers for Medicare and Medicaid Services (CMS).

The ESRD Network Program was established under the ESRD Amendment to the Social Security Act of 1972 for individuals with ESRD. The current CMS strategic goals for the Network Program are:

- Improve the quality and safety of dialysis related services provided for individuals with ESRD
- Improve the independence, quality of life and rehabilitation (to the extent possible) of individuals with ESRD through transplantation, use of self-care modalities (e.g. peritoneal dialysis, home dialysis), in-center self care, as medically appropriate, through the end of life
- Improve patient perception of care and experience of care, and resolve patients' complaints and grievances
- Improve collaboration with providers to ensure achievement of all Program goals through the most efficient means possible, with recognition of the differences between providers (e.g. independent, hospital-based, member of a group, affiliate of an organization) and the associated possibilities/capabilities
- Maintain a patient registry; improve the collection, reliability, timeliness, and use of data to measure processes of care and outcomes and to support the ESRD Network Program

With respect to these goals, CMS uses the Institute of Medicine's (IOM) definition of quality, which is: "The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

As specified in the CMS Statement of Work (SOW), each Network is responsible for conducting activities in the following areas:

- Quality Improvement
- Community Information and Resources
- Administration
- Information Management

A. Network Description

Quality Insights Renal Network 3 serves dialysis providers and patients in New Jersey, Puerto Rico, and the US Virgin Islands. According to the Census Bureau (http://factfinder2.census.gov), these 3 geographic areas have a combined population of 12.62 million people. While these three areas are geographically small in size, New Jersey is the most densely populated state (1,195.5/sq mi) in the country. If Puerto Rico were a state, it would be the second most densely populated (1,162/sq mi)[1].

These dense populations create challenges for providing dialysis to patients, in that there is a greater than average number of patients per dialysis unit in these areas. New Jersey treats an average of 84 patients in

[1] State Population - Rank, Percent Change, and Population Density: 1980-2010. (n.d.). In *Statistical Abstract of the United States:2012* (Tables 14 and 1332). U.S. Census Bureau.

each dialysis unit and Puerto Rico treats an average of 120 patients in each unit, compared to an average of 70.8 nationwide. The US Virgin Islands treats an average of 73 patients in each of its 3 dialysis units.

Population Distribution

The following table shows ESRD incidence rates for 2012 based on data in CROWNWeb, as well as population distributions based on data from the Census Bureau's 2010 census. Quality Insights Renal Network 3 collects and tracks the racial distribution of the ESRD population to properly identify patterns of interest or concern. As *Table A* shows, Network 3 overall has a slightly larger percentage of African American and slighter smaller percentage of White residents than the nation overall.

The large diabetic population is troubling due to the complexities of the disease as well as the percentage of patients who begin dialysis primarily due to diabetes. While all three areas have a rate that is higher than the nation, Puerto Rico in particular has a diabetic rate that almost 50% higher than the national rate, and is higher than any state in the nation.

Incident ESRD Patient Population in Network 3

In calendar year (CY) 2012, 4,848 patients began treatment for ESRD in Network 3, 221 fewer than in CY 2011. The incident rates in New Jersey and the US Virgin Islands dropped in 2012, but the incident rate in Puerto Rico once again increased.

A new data collection system, CROWNWeb, was introduced in June 2012, and thus no conclusions should be drawn from statistics and trends noted. Comparisons of 2012 incidence data to prior years may be the result of new business rules or the interpretation thereof by dialysis unit staff members tasked with entering these data in CROWNWeb.

Table A 2012 Crude Incidence Rates (New ESRD Patients)

State/Territory	Population*	Percent African American	Percent White	Percent Diabetic	Number of New ESRD Patients	Rate Per Million
New Jersey	8,791,894	13.7	68.6	9.2	3,229	367
Puerto Rico	3,725,789	12.4	75.8	12.8	1,498	402
US Virgin Islands***	106,405	76.2	13.1	9.1	38	358
Network	12,627,257	13.8	70.2	10.2	4,848**	383
National	**309,349,689**	**12.6**	**72.4**	**8.7**	**113,626**	**367**

**Population figures derived from US Census Bureau 2010 Census: http://factfinder2.census.gov. **ESRD incident data based on CROWNWeb and total includes patients residing in nearby states such as Pennsylvania, Delaware, and New York. ***USVI racial statistics gathered from CIA World Factbook - https://www.cia.gov/library/publications/the-world-factbook/geos/vq.html*

Prevalent Dialysis Patient Population in Network 3

By the end of CY 2012, 17,709 patients were receiving dialysis treatment for ESRD in Network Three, 395 patients more than in CY 2011. As is illustrated in Table B below, the Network 3 area overall has experienced a consistent increase in the prevalent population over the last 10 years, resulting in an overall increase of 34%. Puerto Rico and the US Virgin Islands in particular have experienced a dramatic rise in the number of prevalent patients being treated, with 45.7% and 51.8% increases, respectively.

This rise in the number of prevalent patients puts a strain on the dialysis centers in these island areas. As described previously, Puerto Rico on average treats a much higher number (120) of patients than the US (70.8) in each dialysis center. While dialysis centers in the US Virgin Islands (USVI) on average treat only slightly more (73) patients, the geographic makeup of this area make access to care more difficult. There are only three dialysis centers in the USVI, one on the island of St. Thomas and two on the island of St. Croix. The center on St. Thomas has reached the maximum number of patients it can treat, which will result in new patients on this island being forced to fly or ferry to centers on St. Croix.

Table B Prevalent Dialysis Patient Data by Year and by State/Territory of Dialysis Treatment

Year	NJ	NJ % Increase	PR	PR % Increase	USVI	USVI % Increase	NW 3	NW 3 % Increase
2003	9,597	--	3,484	--	135	--	13,216	--
2004	9,729	1.4	3,587	3.0	155	14.8	13,471	1.9
2005	10,018	3.0	3,700	3.2	157	1.3	13,875	3.0
2006	10,270	2.5	3,928	6.2	183	16.5	14,381	3.6
2007	10,611	3.3	4,049	3.1	196	7.1	14,856	3.3
2008	10,863	2.4	4,267	5.4	207	5.6	15,337	3.2
2009	11,390	4.9	4,485	5.1	202	-2.4	16,077	4.8
2010	11,656	2.3	4,733	5.5	208	3.0	16,597	3.2
2011	12,208	4.7	4,886	3.2	220	5.8	17,314	4.3
2012	12,158	-0.4	5,076	3.9	205	-7.3	17,709	2.2
10 Year % Increase		**26.6**		**45.7**		**51.8**		**34.0**

Source: Network 3 SIMS Database (2003-2011), CROWNWeb Database (2012). In 2012 there were an additional 270 patients living outside the Network 3 area but are receiving dialysis in Network 3 dialysis units. These patients are counted in the NW3 total but are not represented in the state/territory statistics.

A particular challenge to the health care system in New Jersey remains unauthorized immigrants. The state ranked ninth in the number of unauthorized immigrants, surpassed by California, Texas, New York, Illinois, Florida, Arizona, Georgia and North Carolina. Mexico was identified as the country of origin for 61.5% of these persons[2]. As of December 31, 2012, there were 231 (from 213 in 2011) unauthorized immigrants receiving dialysis in Network 3, all in New Jersey. These patients are not eligible for Medicare and are being treated as charity care.

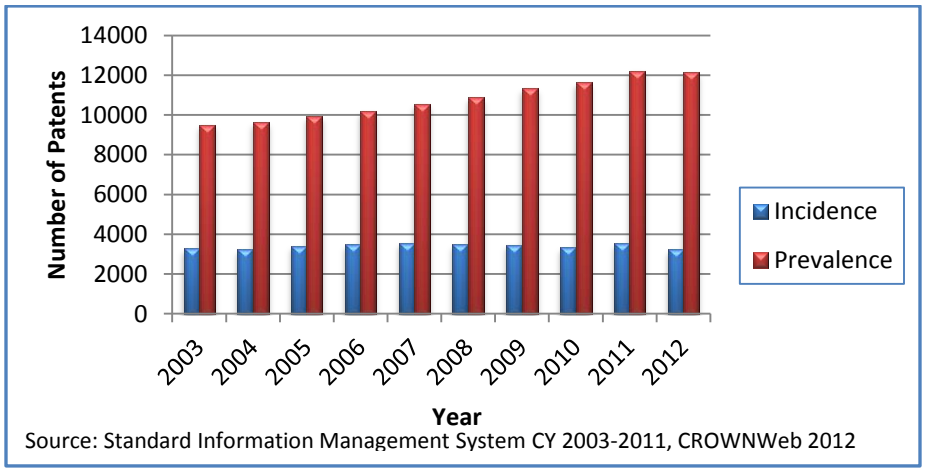
The epidemic of diabetes in Puerto Rico continues to be the leading cause of end stage renal disease in this area. Among incident cases, 65.4% reported a primary diagnosis of diabetes, and diabetes is reported as the primary diagnosis in 60.3% of prevalent patients. As a comparison, in New Jersey diabetes is reported as the primary cause of renal failure in 42.7% of incident patients and 42% of prevalent patients.

Please refer to Table 2 in the appendix of this report for a complete analysis of the prevalent ESRD population by age, gender, race, and primary diagnosis.

A new data collection system, CROWNWeb, was introduced in June 2012, and thus no conclusions should be drawn from statistics and trends noted. Comparisons of 2012 prevalence data to prior years may be the result of new business rules or the interpretation thereof by dialysis unit staff members tasked with entering these data in CROWNWeb.

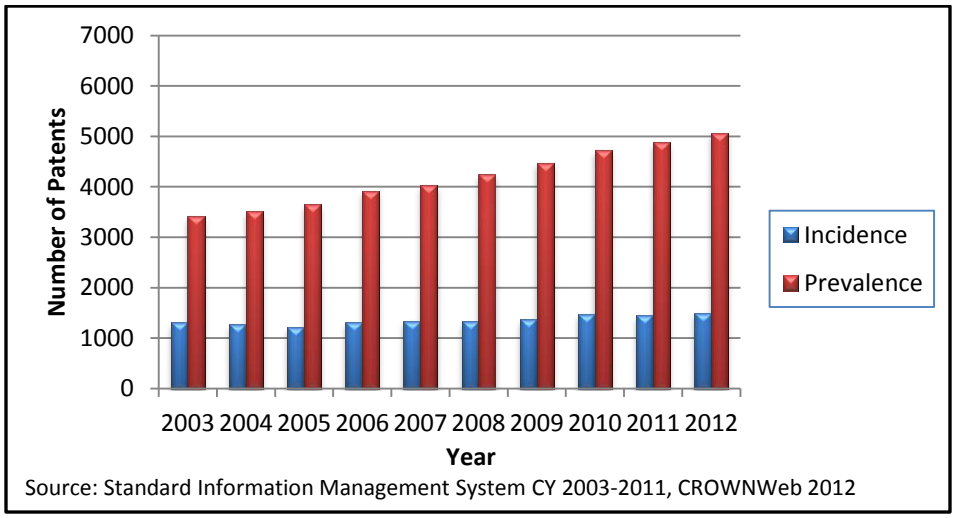
[2] Estimated Unauthorized Immigrants by Selected States and Countries of Birth: 2000 and 2010. (n.d.). In *Statistical Abstract of the United States:2012* (p. 46). U.S. Census Bureau.

Figure 1: Annual Incident and Prevalent Patients in New Jersey - CY 2003-2012



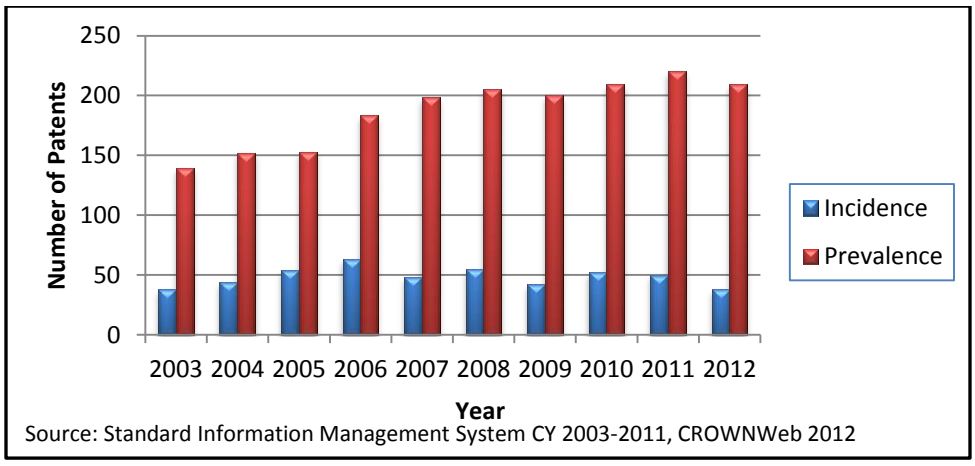
Source: Standard Information Management System CY 2003-2011, CROWNWeb 2012

Figure 2: Annual Incident and Prevalent Patients in Puerto Rico - CY 2003-2012



Source: Standard Information Management System CY 2003-2011, CROWNWeb 2012

Figure 3: Annual Incident and Prevalent Patients in Virgin Islands - CY 2003-2012



Source: Standard Information Management System CY 2003-2011, CROWNWeb 2012

Mortality Data

Death notification reports for ESRD consumers are analyzed by sex, race, and cause of death. The primary cause of death reported in 2012 continued to be cardiac (41.6%), which again reflected national data. Infection was reported as primary cause in 16.5% of the 3,570 death records received. Of all deaths reported in 2012, 71.7% were white, 23.9% black; 57.3% were male, 42.7% female.

As will be detailed later in this report, infections remain a particular concern in Puerto Rico. Infection is much more frequently a cause of death in Puerto Rico than in other areas of the Network, and was reported as primary cause in 25.2% of the 1,054 death records received, compared to just 12.8% in New Jersey.

Please refer to Table 7 in the appendix of this report for a complete analysis of the mortality data for ESRD patients, stratified by age, gender, race, primary diagnosis and cause of death.

A new data collection system, CROWNWeb, was introduced in June 2012, and thus no conclusions should be drawn from statistics and trends noted. Comparisons of 2012 mortality data to prior years may be the result of new business rules or the interpretation thereof by dialysis unit staff members tasked with entering these data in CROWNWeb.

Transplantation

Five renal transplant centers serviced the New Jersey ESRD population, with referrals also being made to neighboring New York, Pennsylvania and Maryland. Recent years have seen an inflow for transplantation to New Jersey from neighboring state residents as well. Organ procurement activities were the responsibility of two federally approved agencies, the New Jersey Organ and Tissue Sharing Network (The Sharing Network) and the Gift of Life Donor Program.

In 2012, 400 transplants were performed in New Jersey at five federally certified ESRD renal transplant centers, a 9.1% decrease from the 2011 total of 440 transplants. In early 2012, CMS de-certified one transplant center in New Jersey, which may have had an effect on the total number of transplants performed.

The number of consumers on a transplant waiting list in New Jersey as of December 2012 increased to 3,060, from 2,900 in 2010. Unless the donor pool is enlarged, transplantation will not be available to the majority of consumers on the list except, perhaps, after a lengthy waiting period. Alternatively, living donor transplantation may provide some candidates with more timely access to this modality.

One renal transplant center in Puerto Rico services the Puerto Rico ESRD population, with referrals also being made to Texas, Florida, Massachusetts and Iowa. Organ procurement activities were the responsibility of Life Link of Puerto Rico, an independent, non-profit organization which performs all aspects of human organ and tissue donation, procurement, and processing for transplantation and research.

In 2012, 87 transplants were performed in Puerto Rico, the same number as performed in 2010. A total of 408 patients are now on the waiting list in Puerto Rico.

There is no renal transplant center in the US Virgin Islands, but 4 dialysis patients were able to receive transplants at off-island transplant centers in 2012.

It is hoped that the recent advent of paired donations may decrease the time that patients spend waiting for an organ to become available and increase the number of transplants overall. Kidney paired donation matches one incompatible donor/recipient pair to another pair in the same situation, so that the donor of the first pair gives to the recipient of the second, and vice versa (http://www.paireddonation.org/).

Figure 4: Renal Transplants performed in New Jersey by Type, 2003-2012

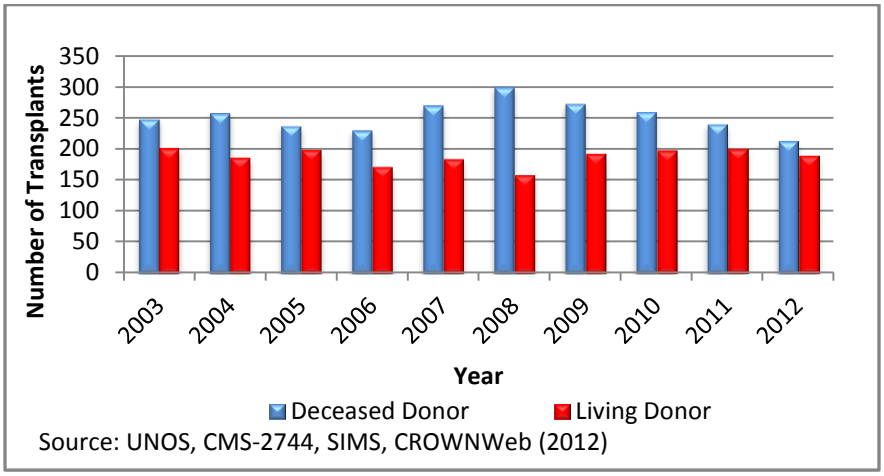
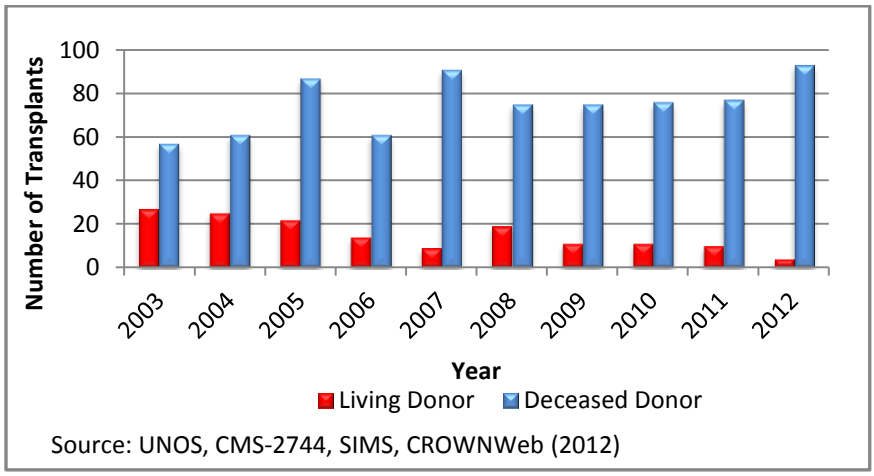


Figure 5: Renal Transplants Performed in Puerto Rico by Type, 2003-2012



B. Network Structure

1) Staffing

Professional and clerical staff conducted daily activities of the Network under the direction of the Board of Directors and in accordance with federal guidance.

2) Names and Titles of Staff

Network 3 is required under contract by CMS to employ an Executive Director and to adequately staff the Network in order to perform the requirements of the scope of work. The names and key responsibilities of Network staff are provided as follows:

Christopher Brown, BS, Executive Director

- Administered the financial and operational aspects of the contract
- Provided advice to the Network governing bodies on goals, objectives, work plans, policies and procedures
- Maintained external relations through ongoing communication with other agencies, state programs and the general public
- Assures quality and timely completion of contract deliverables
- Supervised daily operations.

Beverly Hoek, RN, CNN, Quality Improvement Director

- Provided oversight for all quality improvement efforts
- Planned future project implementation and worked with individual facilities
- Organized and attended Medical Review Board meetings, provided display and analysis for the Medical Review Board
- Conducted quality improvement projects and trend analysis, compiled reports
- Assisted in data collection
- Served as a resource for providers and facility quality improvement staff.

Karen Ripkey, RN, BSN, CNN Quality Improvement Coordinator

- Assisted with the conduct of improvement activities, including data collection, analysis and writing reports.
- Performed on-site facility visits, did clinical data review, responded to consumer problems

Annabelle Perez, RN, BSN, CNN Quality Improvement Coordinator

- Fluent in Spanish, assisted with patient calls related to complaints and grievances
- Assisted with Puerto Rico Healthcare Associated Learning and Action Network in Puerto Rico
- Worked with facilities in Puerto Rico to improve NHSN reporting

June Chronic Huhn, MPA, RN, CNN, Senior Quality Coordinator (half-time)

- Assisted with the conduct of improvement activities, including data collection, analysis and writing reports.
- Performed on-site facility visits, did clinical data review, responded to consumer problems

Community Outreach Coordinator (half-time)

- Planned and facilitated education, information dissemination and training for ESRD professionals, patients and their family members and other members of the community
- Worked in collaboration with the New Jersey Renal Coalition, the State Department of Health, the Quality Improvement Organization and other professional organizations

Joan Wickizer, MSW, LSW, NSW-C, Patient Services Coordinator

- Assumed a proactive role in the facilitation and resolution of patient and/or facility complaints and grievances
- Leads social services, community information and resource activities
- Provides technical assistance and conducts community outreach activities to patients and providers
- Coordinated Patient Advisory Committee and appropriately focused their activities
- Coordinated development of patient newsletters and developed or identified new educational material for dialysis unit personnel and patients
- Promoted an increased awareness of treatment options and rehabilitation through educational programs

Tricia Phulchand, BS, Data Manager

- Developed data analysis and statistical reports
- Assured computer support operations, validation, testing and design of special programs to implement federal directives
- Assured the confidentiality and security of patient data, maintenance of computer systems and updated the patient and facility-specific database
- Served as a resource to providers and Network staff
- Supervised data clerk
- Monitored all project submissions as well as assisted in the implementation of facility testing of CROWNWeb
- Monitored complete and timely data submission

Cheryl Brown, Data Clerk

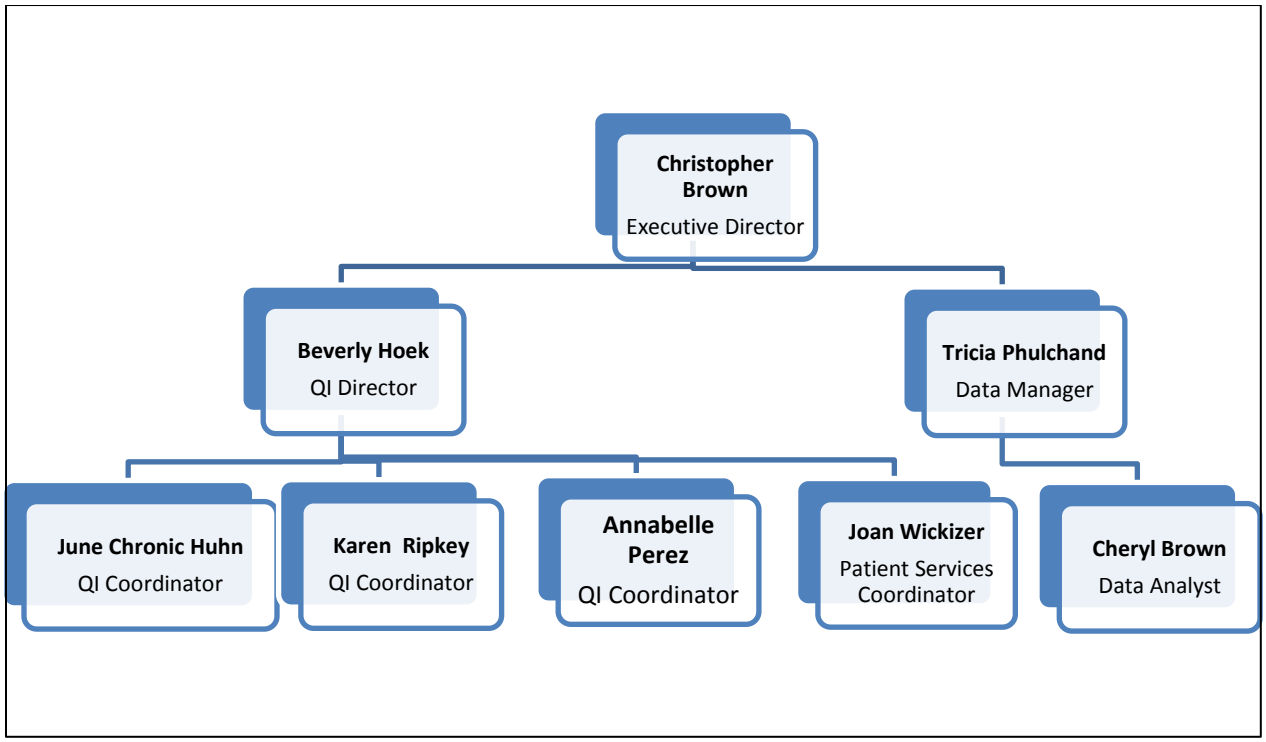
- Performed data entry of medical forms and monthly patient census reports, resolved discrepant reporting, monitored the accuracy and completeness of the database, filed completed forms
- Maintained phone contact with facility staff to answer questions regarding completion of forms and to obtain missing data.
- Supported CROWNWeb by providing technical assistance

These individuals provided the clinical and administrative expertise to assure reliability of statistical data and oversight of quality improvement activities. QIRN3 maintains a relatively small but dedicated staff that continues to meet and at times exceed the expectations and requirements of the contract.

OPERATIONS

There are three major functions within the operation of the Network: better care for the individual through beneficiary and family-centered care, better health for the ESRD population and reduce the costs of ESRD care through improvement of care.

Figure 6. Network Staff Structure



Governance and Committees

The WVMI Board, the Network Board of Directors, the Network Medical Review Board, the Patient Advisory Committee and the Network Council support and facilitate Network operations. Other committees and subcommittees are established when the need arises. Board and committee members include representatives from dialysis and transplant facilities, as well as other strategic organizations in the Network 3 area. Each Board has at least two consumer representatives. The involvement of the consumer representatives is vital to the success of the Network activities and to improving the quality of care and life for the ESRD patients.

WVMI Board of Directors

WVMI is governed by a 16-member board of directors, consisting of physicians, business representatives and consumers. The Board sets corporate policies and assures the orderly and efficient operation of WVMI and QIRN3. The Board has fiduciary oversight responsibility for QIRN3 and reviews its activities as reported by the ESRD Executive Director, Christopher Brown and the Network Board of Director vice-Chairperson, Toros Kapoian, MD. The Board considers and acts on the recommendations from the Network Board of Directors. In addition, ESRD beneficiaries serve as a representative of the renal community.

Board of Directors

The Board of Directors consists of twelve (12) members. The Board of Directors was composed of two consumers, one dietitian, one social worker, two administrators, one nurse, three physicians a Chair and physician Vice Chair. One board member was from Puerto Rico, one from the U.S. Virgin Islands, the

Chair resides in West Virginia and the remaining board members are from New Jersey. The following chart illustrates the Board of Director's composition. John Wiesendanger is the Chairperson, Toros Kapoian is the Vice Chairperson, and Mary Lorenzo is the Secretary/Treasurer of the Board of Directors.

Chairperson	**Title**	**Location**
John Weisendanger	Quality Insights CEO	West Virginia
Vice Chairperson		
Toros Kapoian	Nephrologist	North Brunswick
Members	**Title**	**Location**
Ron Zanger, MD	Nephrologist	Cherry Hill, NJ
Phyllis Micchelli, MSW	Social Worker	East Orange, NJ
Chandra Chandran, MD	Nephrologist	Paterson, NJ
Paula Ruiz de Somocurcio	Registered Nurse	Hackensack, NJ
Ramesh Lakhram, MD	Nephrologist	Saint Croix, U.S. Virgin Islands
Ken Noonan	Consumer	Neptune, NJ
Mary Lorenzo, MSW, LSW	Consumer	Matawan, NJ
Judith Semptimphelter	Administrator	Bridgeton, NJ
Marien Saade	Administrator	San Juan, Puerto Rico
Ellen Cottone, RD	Dietitian	Lawrenceville, NJ

Network Council

The Council provided broad direction and guidance in the development of goals for home dialysis, transplant referrals and criteria selection for monitoring performance of ESRD providers and plans for improvement.

Representation on the Council was multidisciplinary, culled from professionals with demonstrated expertise in their specific field and representative of the geographic characteristics of the Network. In an effort to increase communication between the providers and the Network staff, two branches of the Council were formed in 2009; the New Jersey and U.S. Virgin Island branch and the Puerto Rico branch. Quarterly conference calls were held with each branch and discussions focused around the specific geographic area.

The following charts illustrate the Council's composition. Toros Kapoian, MD is the Chairperson for the Network Council.

In 2012, New Jersey/ USVI Members included:

Members (141)	**Title**	**Location**
Elenita Ajose	Administrator	Jersey City, NJ
Thomas Amitrano	Administrator	Paterson, NJ
Marjorie Arnold	Dietitian	Delran, NJ
Alma Ayala	Administrator	East Orange, NJ
Mary Baker	PD RN	Edison, NJ
Babita Balay	Administrator	Nutley, NJ
Denise Baluyo	Clinic Manager	Neptune, NJ
Karola Behringer	Dietitian	Kenilworth, NJ
Jamie Bellucci	Administrator	Brick, NJ
Yyonnel Berwick	Administrator	Lincoln Park, NJ
Danielle M. Bevere	Dietitian	South Orange, NJ

Members (141)	Title	Location
Michelle J. Bierly	Social Worker	Voorhees, NJ
Bonnie Birnbaum	Dietitian	Newark, NJ
Kathy Bivens	DCI Reg Mgt	North Brunswick, NJ
Keasha Blake	Administrator	Irvington, NJ
Sylvia Bostic	Administrator	Summit, NJ
Christine Boutrs	Dietitian	Hoboken, NJ
Kristine Brooks	Dietitian	Sewell, NJ
Jaime Bradley	Data Contact	Nutley, NJ
Ken Brown	Administrator	Elizabeth, NJ
Mary Buckley-O'Dell	Administrator	Morristown, NJ
Maria Victoria Cipiral	Administrator	Linwood, NJ
Cindy Cano	RV Regional Manager	Passaic, NJ
Ann Caswell	Administrator	Woodbury, NJ
Rosanne Cerchia	Nurse Manager	Neptune, NJ
Ling Chang	Clinic Manager	Newark, NJ
Ruby Codjoe	Head Nurse	Matawan, NJ
Ellen Cottone	Dietitian	Camden, NJ
Karen Craig	Clinic Manager	Union City, NJ
Suzy Cruz	Administrator	Perth Amboy, NJ
Nicole Damiano	Clinic Manager	Red Bank, NJ
Danielle DeFazio	Administrator	Marlton, NJ
Edna Delorenzo	Administrator	Brick, NJ
Elvira Delos Santos	Administrator	Bayonne, NJ
Sara DeLuca	Head Nurse	Runnemede, NJ
Kathy Dericks	Social Worker	Lincoln Park, NJ
Debra DiNuzzo	Dietitian	Neptune, NJ
Mary Ann Dumlao	Administrator	Irvington, NJ
Nancy Elliot	Administrator	Hillside, NJ
Joyce Elwell	Administrator	Sewell, NJ
Brandi Esposito	Administrator	Atlantic City, NJ
Nancy Farmer	Administrator	Colonia, NJ
Marge Fellenbaum	Administrator	Northfield, NJ
Michele Ferrero	Dietitian	Cape May, NJ
Claire Fleming	Dietitian	Bloomfield, NJ
Pamela Firely	Director	Washington, NJ
Nancy Foley	ED Coordinator	Somerville, NJ
Chris Friedlander	Social Worker	Westwood, NJ
Anisa Gandhi	Dietitian	Holmdel, NJ
Pat Gathers	Administrator	Englewood, NJ
Vera Gelito	Head Nurse	Brick, NJ
Marjorie Goldberg	Dietitian	East Orange, NJ
Marilou Gomilla	Head Nurse	Jersey City, NJ
Christine Granz-Harlos	Dietitian	Perth Amboy, NJ
Mary Anne Gunning	Dietitian	Edison, NJ
Angelly Guzman	Social Worker	Union City, NJ
Jeanette Haas	Administrator	Delran, NJ
Sam Harris	Social Worker	Vineland, NJ
Janet Hart	Social Worker	Cherry Hill, NJ
Patricia Hathcock	Social Worker	Newark, NJ
Fran Hatcher	Head Nurse	Northfield, NJ

Members (141)	Title	Location
Alan Hoffman	Dialysis Consumer, PAC	Glen Rock, NJ
Teresa Husbands	Administrator	Newton, NJ
Christine Jaeger	Dietitian	Bridgeton, NJ
Maria Jacoby	Clinic Manager	Camden, NJ
Patti James	Administrator	Burlington, NJ
Elda Jarden	Administrator	Jersey City, NJ
Erin Jones	Clinic Manager	Atlantic City, NJ
Laura Jordan	Social Worker	North Brunswick, NJ
Sue Juliano	Administrator	Teaneck, NJ
Anita C. Kahan	Social Worker	Hoboken, NJ
Melissa Kalman	Social Worker	Irvington, NJ
Amy Kaminski	Dietitian	Millville, NJ
Sebrina Kane	Social Worker	Sewell, NJ
Dawn Kozakowski	Dietitian	Cherry Hill, NJ
Jill Laux	Dietitian	Lincoln Park, NJ
Dawn LaGrippo	Social Worker	Holmdel, NJ
Meredith Leighton	Dietitian	Fairview, NJ
Teresa Leonard	Administrator	Cherry Hill, NJ
Phyllis Leggett	Social Worker	Vineland, NJ
Karen Lee Lioi	Administrator	Passaic, NJ
Melissa Lenny	Dietitian	Sewell, NJ
Urszula Les	Social Worker	Burlington, NJ
Lenna Lipman	QI Regional Manager	Lakewood, NJ
Eileen MacFarlane	Administrator	Hamilton, NJ
Peggy MacMinn	Access Coordinator	Sewell, NJ
Karen Marcus	RV Regional Mgt	Somerville, NJ
Kristen Maresca	Social Worker	Newark, NJ
Maureen Marshall	Administrator	Hillside, NJ
Virginia Martin-Okupinski	Administrator	Pennsauken, NJ
Patty McCann	Administrator	Sewell, NJ
Barbara Melnyk	Administrator	Lakewood, NJ
Araceli Mendoza	Administrator	Bayonne, NJ
Remelyn Mercado	Administrator	Orange, NJ
Barbara Murphy	Administrator	Winslow, NJ
Peggy Navitski	Consultant	Bethlehem Twp, NJ
Susan O'Connor	Administrator	Orange, NJ
Maureen O'Grady-Hamre	Social Worker	Ridgewood, NJ
Ann Panten	Dietitian	Toms River, NJ
Arlene Paquet	Administrator	Fairlawn, NJ
Pamela Peterson	Administrator	Atlantic City, NJ
Peggy Petrusky	Administrator	Willingboro, NJ
Grace Pintabone	Administrator	Maplewood, NJ
Faith Plutto	Administrator	Princeton, NJ
Gemma Pamplona	Administrator	Elizabeth, NJ
Linda Powell	Dietitian	North Brunswick, NJ
Alex Punchello	Administrator	Marlton, NJ
Blanca Rimirez	Receptionist	Nutley, NJ
Deborah Randis	Administrator	Ewing, NJ
Judy Ratcliffe	Administrator	Harrison, NJ
Nelson Ravago	Head Nurse	Bayonne, NJ

Members (141)	Title	Location
Gwen Reisner	Social Worker	Lumberton, NJ
Kim Richards	Administrator	Berlin, NJ
Meredith Rosner	Social Worker	Cherry Hill, NJ
Victoria Ruedt	Dietitian	Newark, NJ
Paula Ruiz	Administrator	Hackensack, NJ
Pam Secor	QI Transplant RN	Ridgewood, NJ
Carla Sedlak	Administrator	Trenton, NJ
Tammy Scovern	Head Nurse	Bridgeton, NJ
Marquita Sharp	Head Nurse	Mount Laurel, NJ
Loryl Steinberger	Social Worker	Fairview, NJ
Barbara Stewart	Administrator	Brick, NJ
Maryann Stewart	Administrator	Brick, NJ
Barbara Stewart	Administrator	Harrison, NJ
Tammy Stiles	Head Nurse	Brick, NJ
Bridgida Suening	Administrator	Hoboken, NJ
Helen S. Sutton	Social Worker	Salem, NJ
Margaret Switzer	Social Worker	Montclair, NJ
Barbara Tepper	Social Worker	Kenvil, NJ
Dana Washington	Social Worker	Orange, NJ
Sharon Wiest	Dietitian	Cherry Hill, NJ
John Wilczenski	Administrator	Middletown, NJ
Andrea Wilson	Social Worker	Vineland, NJ
Eleanor Witkowski	Social Worker	Hammonton, NJ
Linda Wood	Administrator	Trenton, NJ
Kathie Vnenchak	Administrator	Morristown, NJ
Jill QY Zhou	Social Worker	East Orange, NJ
Monica Bet	Head Nurse	St. Thomas, USVI
Ivette Rodriguez	Administrator	St. Croix, USVI
Larry McGowan	Administrator	St. Croix, USVI
Gala Garcia	Administrator	St. Thomas, USVI

In 2012, Puerto Rico (44 total) members included:

Members	Title	Location
Louis Acevedo	FMC Regional Mgt	San Juan, PR
Daisy Baez	Administrator	Cayey, PR
Carla Cancel	Administrator	Carolina, PR
Ana Carrero	Clinic Manager	Aguadilla, PR
Maria M. Cuevas	Clinic Manager	Lares, PR
Elizabeth DeJesus	Clinic Manager	Rio Piedras, PR
Zylkia DeJesus	Administrator	San Juan, PR
Lesly Delgado	Dialysis Nurse	San Juan, PR
Luis Emanuelli	Regional Director	San Juan, PR
Lourdes Feliciano	Head Nurse	Vieques, PR
Evelyn Figueroa	Regional Manager	San Juan, PR
Noemi Figueroa	Clinic Manager	Carolina, PR
Carmen Flores	Clinic Manager	Caguas, PR
John Gage	Special Projects	San Juan, PR
Wishburne Hunt	Nephrologist	St. Thomas, USVI

Members	Title	Location
Mariluz Lopez	Clinic Manager	Arecibo, PR
Kimberly Lundgren	Social Worker	Christiansted, USVI
Ivette Maldonado	Clinical Coordinator	Guaynabo, PR
Luis Maldonado	PD Nurse	Toa Baja, PR
Maria Elena Marrero	Clinic Manager	Carolina, PR
Carmen M. Melendez	Clinic Manager	Caguas, PR
Carmen Montalvo	Clinical Coordinator	Mayaguez, PR
Pascual Muniz	Regional QI Manager	Aguadilla, PR
Azucena Negron	Administrator	Arecibo, PR
Miguel Neris	Administrator	Humacao, PR
Ivette Nolasco	ED Coordinator	San Juan, PR
Nydia Ocasio	Clinic Manager	San German, PR
Waleska Olavarria	Clinic Manager	Ponce, PR
Luz Ortiz	Administrator	Canovanas, PR
Priscilla Ortiz	Clinic Manager	Mayaguez, PR
Marisol Perez Loperena	QI Coordinator	Aguadilla, PR
Ivonne Ramirez	Clinic Manager	San Juan, PR
Sonia Ramos	Clinic Manager	West Ponce, PR
Marie Ines Rebollo	Director of Nursing	San Juan, PR
Glorimar Rios	Administrator	Manati, PR
Glenda Rivera	Head Nurse	Santa Rosa, PR
Janet Rivera Diaz	Clinic Manager	San Juan, PR
Elizabeth Rodriguez	Clinic Manager	Arecibo Norte, PR
Wanda Torres Rodriguez	Administrator	Toa Baja, PR
Awilda Rodriguez	Regional Manager	Aguadilla, PR
Rosa Rodriguez	Administrator	Santa Juanita, PR
Sandra Rosario	RN	Guaynabo, PR
Ana Santi	Clinic Manager	Guaynabo, PR
Aida Serrano	Clinic Manager	Mayaguez, PR
Carmen Serrano	Administrator	Ponce, PR
Blangie Torres Carlo	Regional Manager	Ponce, PR
Evelyn Valle	Clinic Manager	Isabella, PR
Susanna Vazquez	Administrator	San Sebastian, PR
Gloria Vega	Dialysis Nurse	San Juan, PR
Olga Zeno	Regional Mgt	Isabela, PR

Medical Review Board

The Medical Review Board evaluates the appropriateness of ESRD care, treatment procedures, and services delivered to ESRD consumers. The prescribed composition of the Medical Review Board is: fourteen (14) members and a chairperson from the following categories: a minimum of one physician board-certified in nephrology, an experienced nephrology registered nurse responsible for nursing services, a licensed renal social worker, a registered renal dietitian and one patient representative. The MRB consists of prominent and dedicated members of the renal community who volunteer their time.

2012 members included:

Chairperson	Title	Location
Paul Fine	Nephrologist	Morristown, NJ
Members	**Title**	**Location**
Anthony Brown	Nephrologist	
Padmaja Kodali	Nephrologist	East Orange, NJ
Pedro Vergne	Nephrologist	Dallas, TX
Josue Castresana	Nephrologist	Cayey, Puerto Rico
Walter Gardiner	Nephrologist	Saint Croix, U.S. Virgin Islands
Kathrine Dericks	Social Worker	North Brunswick, NJ
Ann Panten	Dietitian	Brick, NJ
Arlene Paquet	RN, Administrator	Fairlawn, NJ
Patricia Madden	RN, Administraotor	Sewell, NJ
Kathy Searson	RN, Peritoneal Dialysis	North Brunswick, NJ
Alex Acevedo	Bio Medical Technician	North Brunswick, NJ
Mani Swaminathan	Dialysis Consumer, PAC Member	Lakewood, NJ
Lenna Lipman	RN, Quality Improvement	
Kevin James	Vascular Surgeon	Morristown, NJ

To further assure a broad perspective on appropriateness of care and outcome measurements, a transplant surgeon, and board certified pediatric nephrologist may serve on the board or as a consultant. These members are selected based on their expertise to further promote the goals and objectives of the Network.

Patient Advisory Committee

The Patient Advisory Committee (PAC) was organized in 2006 with patient volunteers from throughout the Network. The goal of the Patient Advisory Committee is to support the mission of Network 3, to enhance the quality of care provided to ESRD patients and to represent and support the ESRD patient population by actively participating in the committee responsibilities and related functions.

The committee was charged with providing consumer advice to the boards and other committees on such matters as, but not limited to, quality improvement activities, content and format of the Network's web site; content and format of patient educational material; improvement of communication between consumers and facility staff; direct attention to areas/issues of consumer concern.

Committee members attend meetings or conference calls on a quarterly basis and actively participate in the development of patient education programs and the PAC newsletter, *Kidneys R Us.* One of the PAC members attended the CMS Quality Net Meeting in 2012in Baltimore and was on a patient panel. He contributed his story to help personalize the needs of the dialysis patients to CMS, Quality Improvement Organizations (QIO) and ESRD Network staff.

2012 Membership included:

Chairperson	Modality	Location
Kenneth Noonan	Hemodialysis	Neptune, NJ
Members	**Modality**	**Location**
Eric Blocker	Peritoneal Dialysis	Cranbury, NJ
Roslyn Burl-Winkey	Hemodialysis	Newark, NJ
Tara Carty	Hemodialysis	Mountainside, NJ

Loleen Christian	Hemodialysis	St. Croix, VI
John DiFabio	Transplant	Harrington Park, NJ
Angelica DiNatale	Transplant	Hamilton, NJ
Louis Elder, Jr	Hemodialysis	East Orange, NJ
Eileen Figueroa	Hemodialysis	Ponce, PR
Gerald Gibboni	Hemodialysis	Dennisville, NJ
Alan Hoffman	Hemodialysis	Glen Rock, NJ
Hedwig Hoffman	Spouse	Glen Rock, NJ
Karen Irwin	Hemodialysis	Hampton, NJ
Marisol Jimenez	Hemodialysis	Teaneck, NJ
Frederick Lee	Hemodialysis	Hoboken, NJ
Joseph Jean Marie	Transplant	Roselle, NJ
Everisto Mercado	Hemodialysis	Cabo Rojo, PR
Brenda Jones Miller	Hemodialysis	Pine Hill, NJ
Frederick Lee	Hemodialysis	Hoboken, NJ
Kye Martin	Hemodialysis	Christiansted, VI
Karen Oakley	Hemodialysis	Whippany, NJ
Morris Perugini	Hemodialysis	Mt. Arlington, NJ
Ethel Redwood	Hemodialysis	Newark, NJ
William Reineman	Hemodialysis	Hoboken, NJ
William Senior II	Hemodialysis	Trenton, NJ
Michael Smith	Hemodialysis	Cherry Hill, NJ
Mani Swaminathan	Hemodialysis	Brick, NJ

III. CMS National Goals and Network Activities

The Medical Review Board (MRB), Board of Directors and the Network Council reviewed national CMS goals set forth in the Network's contract. The committees then formulated sub-goals and activities for the contract year. The sub-goals are used to focus attention on and promote action in specific areas of nephrology practice to attain national goals and improve the quality and delivery of health care services.

A. Improve the quality and safety of dialysis-related services provided for individuals with ESRD

The contract year has never coincided with the calendar year. In June 2012 our current contract expired and Network 3 received a 6 month extension as did all 18 Networks. During the July 2011- June 2012 contract year, Network 3 decreased the catheter > 90 day rate by 1.9 percentage points. This exceeded the Network stretch goal of 1.5 percentage points. The Network goal for increasing the percentage of AVFs was 1.7%. According to the last CMS collected data, the Network increased the AVF rate by 2.0%.

On July 1, 2012, Network 3 received a 6 month extension of the previous year's contract. The goals established by CMS are represented below.

Supportive Activities

Network 3 developed quality improvement projects with the direct guidance from its MRB and through partnerships with the Patient Advisory Committee and Network Council. The framework of these efforts was developed in a comprehensive Quality Improvement Work Plan (QIWP), addressing four major tasks:

1. Vascular Access (Fistula First Breakthrough Initiative) Network 3 had two goals under this task:
   a. Increase the percentage of AV fistulas by 0.7 percentage points from July 1, 2012 to December 31, 2012.
   b. Decrease the percentage of catheters > 90 days by 1 percentage point from July 1, 2012 to December 31, 2012.
2. Clinical Performance Measures
   a. Increase the weighted clinical scores at targeted facilities to equal or exceed Network mean in the areas of:
      - Adequacy
      - Hemoglobin > 12 g/dL
      - Catheters > 90 days
3. Facility Specific Quality Improvement
   a. Greater than 90% of Network facilities will complete registration in the CDC National Healthcare Safety Network and report 3 months of data.
   b. Decrease Healthcare Associated Infections in Dialysis Facilities in Puerto Rico
4. Network Specific Quality Assessment Performance Improvement (QAPI)
   a. Focused facility monitoring – U.S. Virgin Islands maintain compliance with Conditions for Coverage

Network Results

Task 1 - Vascular Access (FFBI)

a. Increase the percentage of AV fistulas by 0.7 percentage points

Background: In 2003, CMS launched with all Networks the National Vascular Access Improvement Initiative, now called the Fistula First Breakthrough Initiative. The project was based on the NKF-KDOQI guidelines, which stated that 65% of prevalent hemodialysis patients should use an arteriovenous fistula and 50% of incident patients should use an arteriovenous fistula. Hemodialysis patients with fistulas have improved morbidity and mortality outcomes.

Since the inception of the *Fistula First* initiative in 2003, Network 3 has sponsored educational programs for vascular surgeons, nephrologists, nurses and technicians in New Jersey, Puerto Rico and the US Virgin Islands. Targeted interventions were focused on lower performing facilities that were required to complete a root cause analysis and improvement plan. Data was submitted monthly to track progress.

With the release of CROWNWeb on June 14th, 2012, the Fistula First dashboard was temporarily placed on hold until data is available through CROWNWeb. At the time of this report the date for release of the July through December 2012 vascular access data is June 28, 2013. The last data the Network has comes from the Fistula First Dashboard in April 2012.

Goal: Increase the prevalent AVF rate by 0.7 percentage points by September 2012

Project Results: Each year the Network was challenged by CMS to achieve an established goal. During the 6 month extension in 2012, the Network's goal was to increase the prevalent AV fistula rate by 0.7 percentage points by September 2012. According to the April 2012 data, the Network 3 AVF rate was 59.3%.

As of April 2012, the fistula rate in New Jersey was 62.5%. In Puerto Rico, the progression has been slow; the April fistula rate was 51.5%. The large majority of patients live in the metropolitan San Juan area where the largest privately owned hospital is located. This hospital does not accept Medicaid (known in Puerto Rico as Mi Salud) patients which delays or prevents vascular access surgery until the patient is admitted for emergency services and a vascular access can be placed. The April 2012 fistula rate in the US Virgin Islands was 53.1%.

b. Decrease the percentage of catheters > 90 days by 1% annually

The USRDS Morbidity and Mortality Study Wave 1 showed that patients receiving catheters and grafts have greater mortality risk than patients dialyzed with fistulae. The Network goal established July 1, 2012 for catheters > 90 days was a 1 percentage point reduction. As of April 2012, the percentage of patients in Network 3 with a catheter > 90 days was 10.1%, in New Jersey the rate was 9.4%, Puerto Rico 12.3%, and the U.S. Virgin Islands had only 3.5%.

In April 2013, Network 3 had 173 hemodialysis providers, 32 (18%) had achieved >70% AVF rate, 49 (28%) had achieved the CMS goal of 66%. A total of 147 facilities had an AVF rate of at least 51%.

Figure 7: Number of Facilities by AVF Rate

Rate of AVF Use among Prevalent Hemodialysis Patients	Number of Facilities	Total Number of In-Center Patients In Facilities
<31%	1	18
31%-40.9%	4	336
41%-50.9%	31	3033
51%-65.9%	98	8,023
66%-70.9%	23	2440
71%-80.9%	22	2013
81%-100%	4	332
	Total Number of Providers 173	Total Number of Patients 16,195

Source: Provider vascular data reports April 2012

Of the 36 facilities in Network 3 listed above with AVF rates less than 51%, fifty percent are in Puerto Rico and the remainder is in New Jersey. There were 3,387 patients located in these facilities, 36% of the patients are located in New Jersey. The 36 facilities are equally divided between large dialysis organizations and independent facilities.

Figure 8: Number of Facilities by AVF Rate

Rate of Catheters > 90 days Among Prevalent Hemodialysis Patients	Number of Facilities	Number of Patients With Catheter > 90 days
< 1%	6	2
>1% -< 10%	96	574
10%-14.9%	41	478
15%- 24.9%	25	491
25%-29.3%	5	115
	Total Number of Providers 173	Total Number of Patients with a Catheter > 90 days 1660

Source: Provider vascular data reports April 2012

As is illustrated in the table above, 59% of the Network facilities have met the National Kidney Foundation's, Kidney Disease Outcomes Quality Initiative (NKF KDOQI) Guidelines of less than 10% of patients utilizing a long term catheter. The 5 facilities with the highest percentage of patients with a catheter > 90 days consisted of 2 hospital facilities with 75-135 patients; one in Puerto Rico and one in New Jersey. The remaining facilities consisted of 1 LDO facility in Puerto Rico and 2 small (fewer than 20 patients) facilities; one in New Jersey, the other in Puerto Rico.

Feedback Reports

Vascular Access Reports

Multiple approaches to achieving the CMS and Network goals are developed and utilized by Network staff, as not all interventions are successful in all Network territories. The Network has set individual facility goals based on March data for the last several years.

The facility specific goals were reported in the quarterly vascular reports which was suspended in April following the implementation of CROWNWeb.

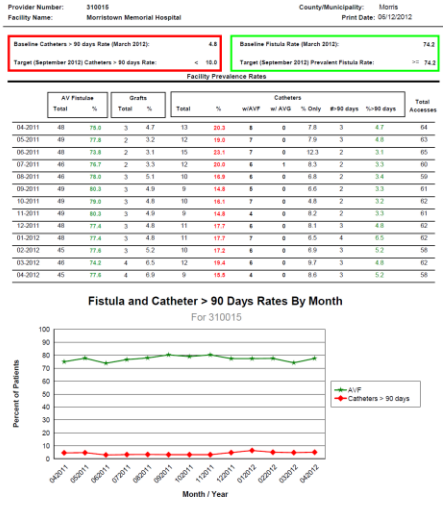
Educational Programs

Multiple educational programs related to the Fistula First Breakthrough Initiative were held during 2012, programs included:

- Puerto Rico Annual Meeting on March 4, 2012
- Renal Disease Symposium on March 22, 2012
- WebEx on April 24, 2012, Second Wave Facility Performance Scores
- Renal Disease Symposium on October 26, 2012
- WebEx on August 7, 2012, Understanding the DFR and 2015 QIP Rule
- NW Annual Meeting, October 4, 2012 included the presentations *The Future of Fistula First* and *The 2015 Quality Incentive Program*.
- WebEx on November 29, 2012 *Dialysis Adequacy*

Collaboration

For decades dialysis facilities and Networks have worked within their individual silos, rarely stepping outside to seek assistance in performance improvement activities. This all changed 7 years ago when CMS encouraged Networks to form coalitions and work with others within the healthcare community.



Over the last 7 years QIRN3 has cultivated collaborative relationships with many organizations serving healthcare consumers. The following are just a few examples of collaborative activities that QIRN3 has engaged in during 2012:

- QIRN3 established a Learning and Action Network in Puerto Rico in March 2012 to Decrease Healthcare Associated Infections and Reduce Catheters. Members include:
  - ANNA, Caribbean Chapter
  - LifeLink Foundation – Puerto Rico OPO
  - Auxilio Mutuo Hospital – Large metropolitan hospital

  - La Sociedad de Nefrología e Hipertensión de Puerto Rico
  - Fundación del Riñón - Puerto Rico Kidney Foundation
  - Veteran's Administration
  - Consejo Renal
  - Fresenius Healthcare
  - Atlantis Healthcare
  - Independent Dialysis Providers and Consultants
  - Puerto Rico Hospital Association
  - QIPRO - Quality Improvement Professional Research Organization- Puerto Rico QIO
  - Asociación de Enfermeras y Enfermeros Epidemiologos de PR - Society of Epidemiology
- Educational programs - ANNA in New Jersey and Puerto Rico
- The ANNA Caribbean Chapter provided an all-day conference for dialysis nurses on infection control and reducing HAIs.
- La Sociedad de Nefrología e Hipertensión de Puerto Rico, provided an all-day physician conference on decreasing HAIs.
- QIRN3 Quality Improvement Director is a member of the New Jersey QIO - Healthcare Quality Strategies, Inc., Reducing Healthcare-Associated Infections Learning and Action Network Advisory Committee and CLABSI subcommittee
- QIRN3 collaborates, through monthly conference calls, with the New Jersey and Puerto Rico DOH.
- The New Jersey Hospital Association in collaboration with QIRN3 provided a Comprehensive Unit-based Safety Program (CUSP) education program for dialysis facilities.
- QIRN3 has collaborated with the National and local offices of the Association for Professionals in Infection Control and Epidemiology (APIC). APIC provided the contact information for an APIC speaker to provide infection control education in Spanish for staff in Puerto Rico.
- The North and South chapters of APIC in NJ and QIRN3 provided an educational program on *Bridging the Communication Gap* between dialysis facilities and hospital infection control practitioners to enhance reporting in NHSN.

Task 1.b. ESRD Clinical Performance Measures

Annually, CMS utilized the National ESRD Elab Data to collect data for a national set of measures from 100% of eligible dialysis patients in clinical areas that included dialysis adequacy, anemia management, nutrition and bone management. This collection was completed each year in February and March, and was based on patient clinical data from October, November and December of the preceding year.

The Elab project was suspended in 2012, following the implementation of CROWNWeb. The Network Boards utilized the most recent data available to the Network, which was the 2011 Elab data collection, to establish the 2012 goals.

Figure 9: 2012 Network Clinical Goals

Hemodialysis Indicator	Goal
Annual Hgb >12 g/dL reduction (ESA only)	≥ 2%
URR ≥65%	≥ 95%
Albumin ≥ 4.0/3.7g/dL(BCG/BCP)	≥ 39%
TSAT ≥ 20%	≥ 91%
Phosphorus ≥7mg/dL	≤ 10%
Phosphorus ≤ 5.5 mg/dL	≥ 68%
Fistula rate prevalent patients	≥ 66%
Fistula rate incident patients	≥ 50%
Catheters >90 days	≤ 10%

Facility-level statistics provided through the data collection efforts were analyzed and if results were less than the national average or less than the threshold established by the Medical Review Board, providers were required to develop internal improvement efforts in the area.

The chart below demonstrates the sustained improvement the facilities have made in achieving Network goals between 2007 and 2011. As noted, the clinical parameters have changed over the years to reflect current practice guidelines and the results are reported based on the target range for the specific year.

Figure 10: Network 3 Goal Attainment Progress

Measures	2008	2009	2010	2011	U.S. (2011)
Hgb target range 10-12 g/dL	55.6%	61.7%	71.1%	73.7%	73.9%
Mean URR ≥ 65%	91.3%	93.1%	93.2%	95.5%	95.2%
KT/V ≥1.2	95.1%	96.3%	96.4%	97.6%	97.2%
Mean Alb ≥ 4.0/3.7 g/dL	35.7%	36.0%	39.1%	39.7%	42.2%
Mean TSAT ≥ 20%	87.1%	87.6%	89.3%	91.2%	88.6%
Mean Ferritin in range	65.7%*	58.7%**	55.0%	36.1%	43.2%
Adjusted Calcium 8.4-10.2 mg/dL	81.3%	81.9%	81.8%	81.8%	82.3%
Mean Phosphorus 3.5-5.5 mg/dL	56.0%	57.4%	58.3%	59.4%	57.1%
Prevalent Patients AV Fistulas	49.0%	54.3%***	57.1%***	59.1%***	60.3%
Incident Patients AV Fistulas	48.0%	37.9%***	34.1%***	39.0%***	36.7%
Prevalent Patients Catheter ≥ 90 days	23.0%	12.5%	12.1%	10.8%	NA

*** Range 100-800 ng, ** Range 200-800 ng, *** FFBI dashboard**
2006-2007 CPM data collection, 2008-2009 National ESRD Elab data collection

Clinical Performance Score Project:

Background: The Clinical Performance Scores Project initiated in 2011 with the approval of the Medical Review Board, allowed facilities to compare their performance to other NW facilities and assist them to improve in three clinical areas chosen by the Boards. The project coincided with the introduction of the CMS QIP (Quality Incentive Program) in July 2011 and was designed to assist facilities to become educated on the QIP and improve their outcomes.

Selection Criteria:

Wave 1: Facilities with a Performance Score two standard deviations below the NW mean (22) as indicated by self-reported data. The first wave began in August 2011 and continued through the end of 2012 until facilities demonstrated sustainable scores. Facilities failing to sustain improvemet were rolled into the second wave for continuation of monitoring.

Wave 2: Facilities with a Performance Score one standard deviation below the NW mean (22) as indicated by self-reported data. The second wave was rolled out to facilities in April 2012.

Project Goal: Assist selected facilities to improve and sustain their clinical performance at or above the NW mean by focusing on clinical indicators in need of improvement as demonstrated by their monthly scores.

Project Description:

The NW clinical scoring project utilized the CMS ESRD QIP (Quality Incentive Program) formula to calculate performance scores for facilities based on their Elab data. A weighted performance score was calculated using three clinical indicators chosen by the NW Boards: URR >65%, Hgb >12g/dL and catheters >90 days. An unweighted score composed of three other indicators (phosphorus >7mg/dL, AVF rate and catheter rate) was also included and provided to facilities to compare performance in these areas to the NW performance.

Data was analyzed and NW3 facilities were ranked according to their weighted scores. Those scoring two standard deviations below the mean NW3 weighted score of 22 were chosen for the Wave 1 of the project. Facilities scoring one standard deviation below the NW were entered into Wave 2 rolled out in April 2012.

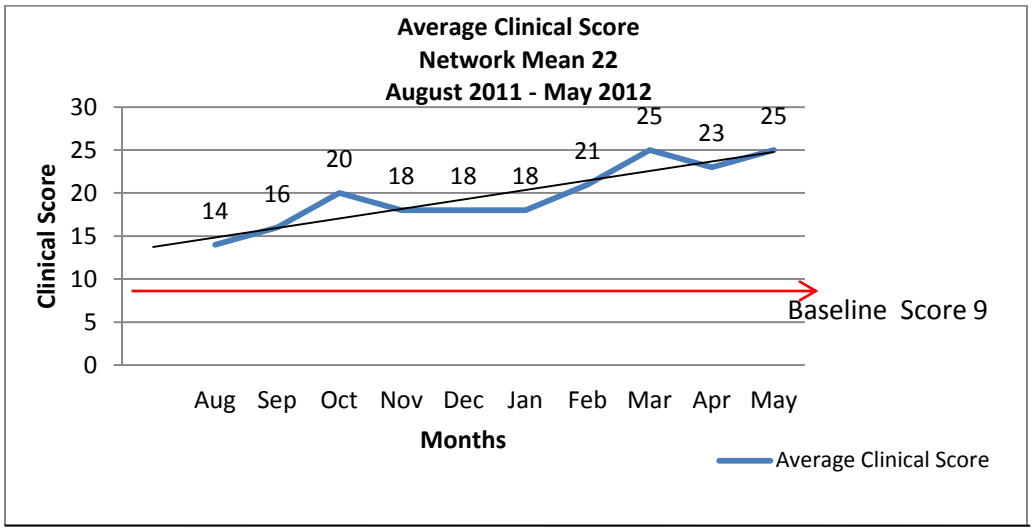
Facilities meeting the Network criteria were notified of project inclusion by mail. Each facility was provided with a description of project activities and goals. Activities included:

- Collection of current data to validate inclusion in project
- WebEx to review data and project expectations
- Review of Network data collection tool which calculated clinical score based on facility's percentage of patients achieving the quality indicator
- Monthly data collection
- Periodic conference calls to review progress and barriers
- Development of QAPI, if indicated

Outcome:

Wave 1: This project was a continuation of the performance scores initiative begun in 2011. Four facilities in Wave 1 were required to submit improvement plans at the end of 2011. The Wave 1 group, as a whole, improved and in March 2012, eight were consistently submitting scores at or over the NW mean and at year's end, they were no longer required to submit data due to sustainability of their scores.

Figure 11: Wave 1 Average Clinical Performance Scores Aug 2011-May 2012



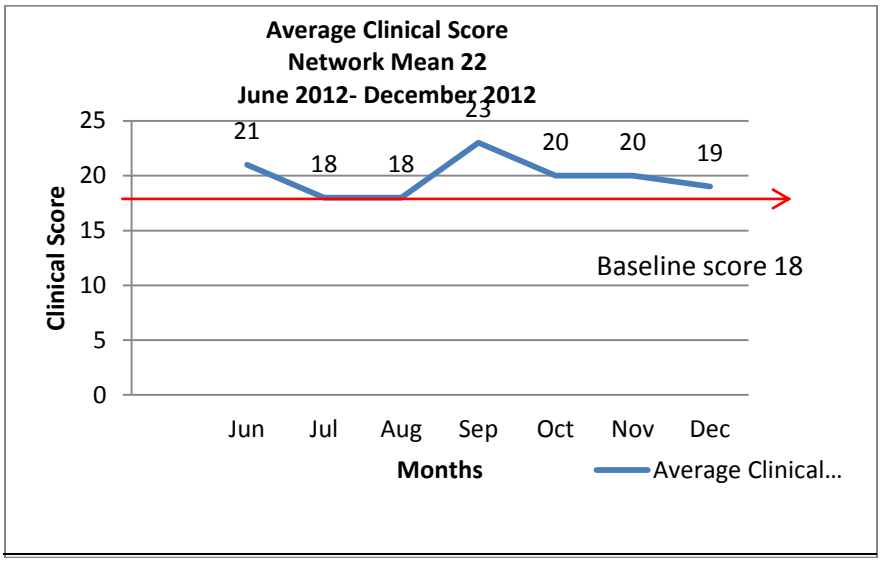
Wave 2 began in April 2012 with a WebEx and collection of current data to validate inclusion in the project. Ten identified facilities submitted data monthly-three in NJ and seven in Puerto Rico. Additionally, the performance score data from an eleventh facility was also monitored during this period. This particular facility was part of the local SDO in Puerto Rico and had participated in the first wave of the project. During four of the six months they had scores at the NW mean of 22, but there was no evidence of long-term sustainability. Due to high infection and mortality rates at this facility, the Network included them, to help improve the facility's performance and patient safety.

Improvement plans were required of four of the Wave 2 facilities and were received and accepted in September 2012. At the end of six months, the Wave 2 group as a whole did not demonstrate a sustained increase in scores and failed to achieve the average NW mean of 22. Three facilities, 2 in New Jersey and 1 in Puerto Rico were no longer required to submit data due to sustained improvement.

Of the slower performers, all are located in Puerto Rico; two facilities are part of the national LDO, four belong to the local SDO and one is a hospital based facility. In December 2012, the NW contacted the quality managers of each of the corporations with attached copies of the data submitted by their facilities as part of the project. Improvement plans were requested and these facilities will be included in the project in 2013.

The problems facilities in Puerto Rico have had in achieving better performance scores, are related to the widespread failure to reduce catheter rates, hemoglobins greater than 12, and to consistently provide adequate dialysis to their patients. Despite improved communication since the hiring of a bilingual nurse by the NW, there remains a basic lack of understanding and follow through with the processes needed to achieve and sustain improvement in anemia management and adequacy. The challenges of vascular access management in Puerto Rico are discussed earlier in the report.

Figure 12: Wave 2 Average Clinical Performance Scores Jun –Dec 2012



Task 1.c. Network Specific Quality Improvement

Network-specific quality improvement activities are implemented network-wide. The activities are directly aligned with the areas of most need and potential impact for quality improvement. The Network developed the quality improvement projects under the guidance of the Medical Review Board, Patient Advisory Committee, Network Council, local providers and State agencies.

CMS encourages Networks to undertake activities in any of 18 pre-approved priority areas or seek approval in other areas from the Project Officer.

The Board in collaboration with the State agencies and the Patient Advisory Committee selected infection control as the primary initiative. QIRN3 approached this project in two ways:

a. Increase the percentage of NW3 facilities participating in the CDC NHSN reporting
b. Decrease the Healthcare Associated Infection rate in Puerto Rico
c. Develop Learning and Action Network

NHSN Dialysis Event Reporting:

In December 2010, the Board members voted unanimously to add the participation in the CDC NHSN Reporting as a Network goal. Network facilities were notified of the revised goal statement and the facility administrators were contacted to advise them of the plan. The CDC provided multiple training sessions via WebEx, in addition to providing recorded sessions available on the internet.

While registration became a bigger challenge than anticipated, the CDC reported at the end of 2011 that 95% of Network 3 facilities had successfully enrolled. The few remaining facilities were in the process of change in ownership and were awaiting new provider numbers. In 2012, the Network provided additional training sessions and began the process of data validation. Throughout 2012, the Network worked with individual facilities to improve reporting by reviewing data and assisting the facility to

identify the correct source of infection. Monthly, the Network ran the CMS QIP Rule report in NHSN and contacted facilities to correct errors to ensure compliance with the QIP Rule.

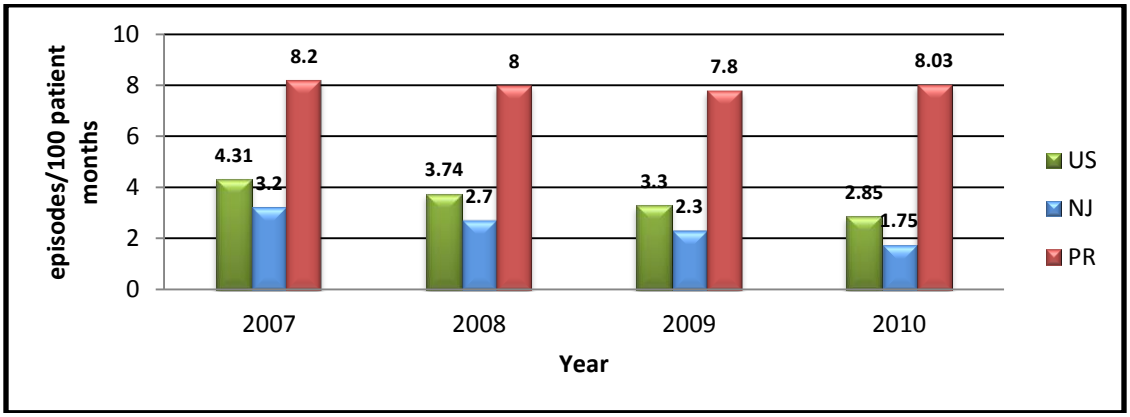
At the time of this report, CMS has extended the deadline for data submission for 4th quarter 2012 until April 30, 2013. The majority of Network 3 facilities have 12 months of data in NHSN. The Network is missing data from 22 DaVita facilities.

Decreasing Healthcare Associated Infections

Background: Each year, the University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) under contract from CMS develops and distributes through ESRD Networks a facility annual Dialysis Facility Report (DFR). This extensive report provides trended (4 years) facility information compared to the local state, Network and national results, on several clinical measures. Several sources of information are used for this analysis such as Medicare claims, hospitalization events, and CMS ESRD specific forms.

The July 15, 2011 release of the Annual Facility Supplemental Report contained new vascular access infection rates. According to the data, Puerto Rico dialysis facilities had a Dialysis Access-Related Infection rate of 8.03/100 patient months compared to the US and New Jersey values of 2.85 and 1.75/100 patient months respectively. Since this was new data not previously reported, there was limited comparison data. However, the graph below illustrates the improvement in the US and New Jersey over the last 4 years while Puerto Rico sustained an infection rate 2 - 4 times higher than the US and New Jersey.

Figure 13: Vascular Access Infection Rate by Region



❖ 2011 USRDS Dialysis Facility Report

Data reported in the Dialysis Facility Report is limited to Medicare claims data which excludes a significant portion of the population in Puerto Rico (patients on Medicaid). This could mean that the infection rates may be significantly higher than this report represented. Figure 17 illustrates the vast difference in improvement rates over the last 4 years in New Jersey and the United States compared to Puerto Rico. The US decreased the number of infections/100 patient months by 33.9% and NJ by 45.3%; while Puerto Rico has held steady at approximately 8 episodes per 100 patient months for all 4 years.

Analysis of the infection rates showed that 12 facilities had infection rates higher than the territory average. Facility rates ranged from 8.81 to 20.6 infections/100 patient months. Eleven of the facilities were located in the San Juan metropolitan area, 3 were owned and operated by a local Small Dialysis Organization (SDO) and 9 were owned and operated by a national Large Dialysis Organization (LDO). Two facilities in Puerto Rico had infection rates equal or below the national average, both belong to the

local SDO. The remaining 25 facilities had rates between 4.21 and 8.0 infections/100 patient months. Figure 14 below displays the infection rates at the 39 facilities.

Figure 14: 2010 Infection Rates in Puerto Rico by Facility

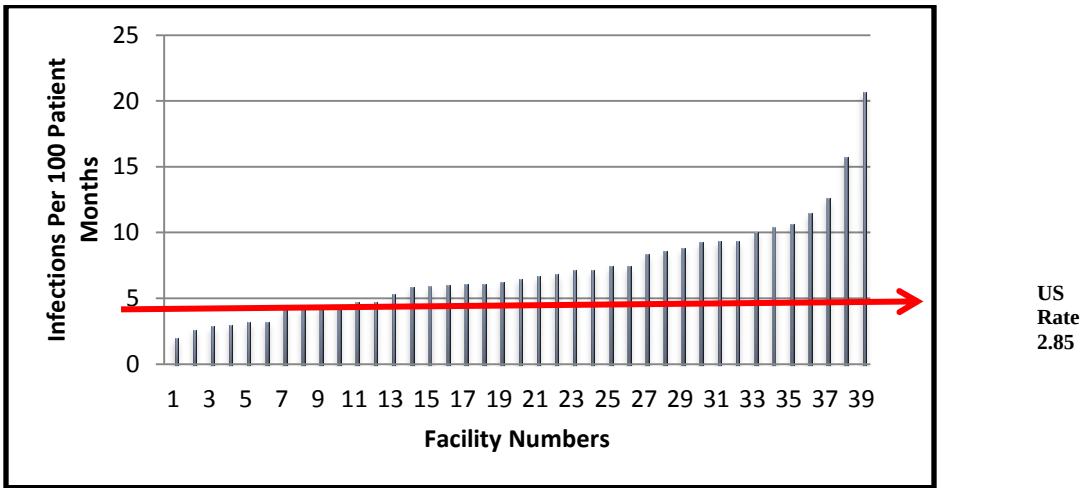
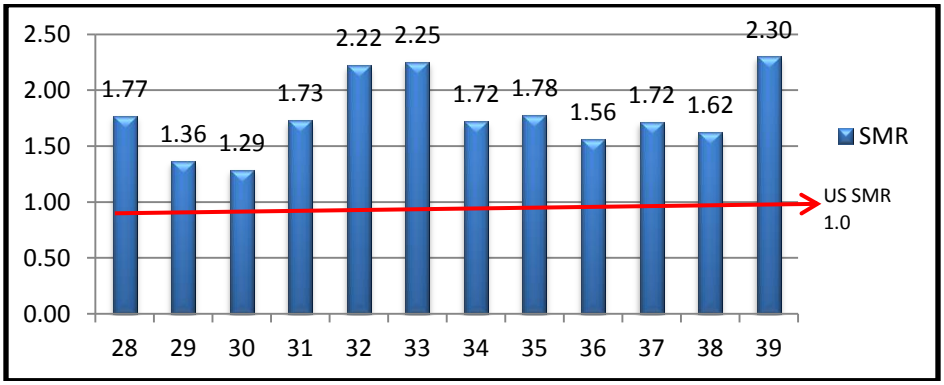


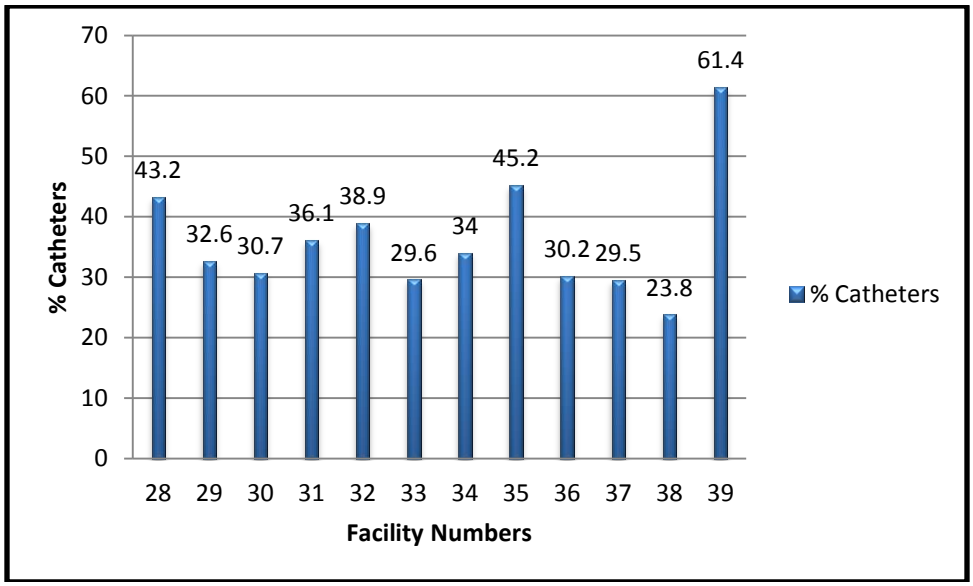
Figure 15 reveals the mortality ratios at the 12 targeted facilities. Facility 39 in Figure 15 had an infection rate of >20/100 patient months according to claims data reported in the Dialysis Facility Report. The mortality ratio at this facility was 2.3 compared to the US mortality ratio of 1.0. Figure 21 shows that facility 39 had a catheter rate of >61%. Only three of the 12 targeted facilities had catheter rates below 30%.

Figure 15: Standarized Mortality Ratio at 12 Targeted Facilities*



*Dialysis Facility Reports

Figure 16: Catheter Rates at 12 Targeted Facilities*



*Facility Vascular Access Reports

Project Description

Corporate and local leadership staffs were immediately notified of the data. The facilities were asked to complete a root cause analysis and develop a quality assessment improvement plan (QAPI) which was submitted to the Network for review and approval.

The Network developed a strategic plan and discussed this plan with CMS and the Network Boards. The plan included education, technical assistance, monitoring, on-site visits, validation of data, review of policies and procedures and oversight of performance improvement.

Education/Monitoring
A webinar was held to review the findings and describe the Network interventions. The attendees were required to complete two modules in the 5 Diamond Patient Safety Program; patient safety principals and hand hygiene and submit monthly data to the Network for review and analysis.

The monthly data submission included:
a. Monthly staff education related to infection control
b. Monthly Infection report
c. Monthly Antibiotic Usage report
d. Monthly Hospitalization report
e. Monthly Performance Improvement minutes
f. Monthly hand hygiene and catheter care audits

All facilities in Puerto Rico were required to report all infections into NHSN for October, November and December 2011 and monthly in 2012. The Network then compared the data entered into the NHSN system to the data submitted monthly from the 12 targeted facilities. Feedback was provided each month; problems were discussed with local and corporate leadership and quickly resolved. Additional webinars were provided by Network staff to reinforce accurate data entry and provide instruction on how to use the NHSN data reports for performance improvement activities.

The facility specific improvement plans submitted to the Network lacked content and indication of a true root cause analysis and all were rejected by Network QI staff. Corporate leadership was contacted and a corporate plan was requested. The LDO corporate staff sought technical assistance from Network staff and demonstrated commitment and initiated aggressive interventions. The corporate plan was comprehensive and approved by Network staff. The SDO discussed their plan with the BOD Chair and a physician at the CDC, some aspects of which raised additional concerns; the SDO plan was not approved by the Network and was not revised per Network request.

Monthly documentation of multiple in-services at many levels (Medical Directors, patients, nephrologists, patient care staff, ancillary staff) were submitted to the Network as proof of dedication to the problem from all targeted facilities. Individual facility meetings as well as regional meetings were held.

The Network hosted a Webinar on Best Demonstrated Practice provided by Atlantic City Medical Center, an inner city hospital in New Jersey that had experienced a high infection rate and through a focused quality improvement program decreased the infection rate from 3.34 to 0.32 infections per 100 patient months over a period of approximately 2 years. The program was well attended and the Network received positive feedback.

Annually, the Network holds its annual education program in Puerto Rico in March or April. Historically, the program was held during the week and was attended primarily by leadership staff. Based on recommendations of local Board members it was decided to hold the 2012 annual meeting on a Sunday to allow for clinical staff to attend. The entire program was focused on infection control and was done in Spanish. The physician leads, Priti Patel, MD and Alexander Kallen, MD of the CDC Hemodialysis Collaborative were asked if they could recommend a Spanish speaking physician from the CDC to present at the annual meeting. Suggested topics included: Multi-Drug Resistant Organisms and Decreasing Healthcare Associated Infections in the Dialysis Facility. The CDC recommended Neil Gupta, MD; who participated.

Network staff also contacted APIC national headquarters in Arlington, VA, to see if they could recommend a physician who would cover the *APIC Guide to the Elimination of Infections in Hemodialysis* in Spanish at the annual meeting. They offered to translate the Guide into Spanish for use in Puerto Rico and recommended Mario Melgar, MD, who also participated. The meeting was held on March 4, 2012 and was attended by over 300 participants.

On-site visits were conducted February 28 through March 3, 2012, during which data validation, staff re-education and technical assistance was provided.

The entire experience has been enlightening. Standard clinical practice was found to be absent in several facilities. Antibiotics were given routinely without benefit of cultures in a few locations, patients with multi-drug resistant organisms (MDRO) were not cohorted, hand hygiene compliance was poor, catheter at home is extensive and is done without the provision of supplies or instruction, patients were not washing their vascular access before dialysis, and several process issues, including blood cultures.

Monthly conference calls were held with the Puerto Rico Department of Health and CMS during which Network concerns and interventions were discussed. A member of the survey team presented at the annual meeting on the most frequently cited infection control deficiencies.

The LDO has permitted the facilities in Puerto Rico to adopt the CDC Core Interventions and implemented a comprehensive infection control audit. Each month 25% of the facilities staffs are audited for infection control compliance. They have implemented progressive disciplinary action for employees

who fail to demonstrate improvement and monthly education is provided at each facility for staff and patients.

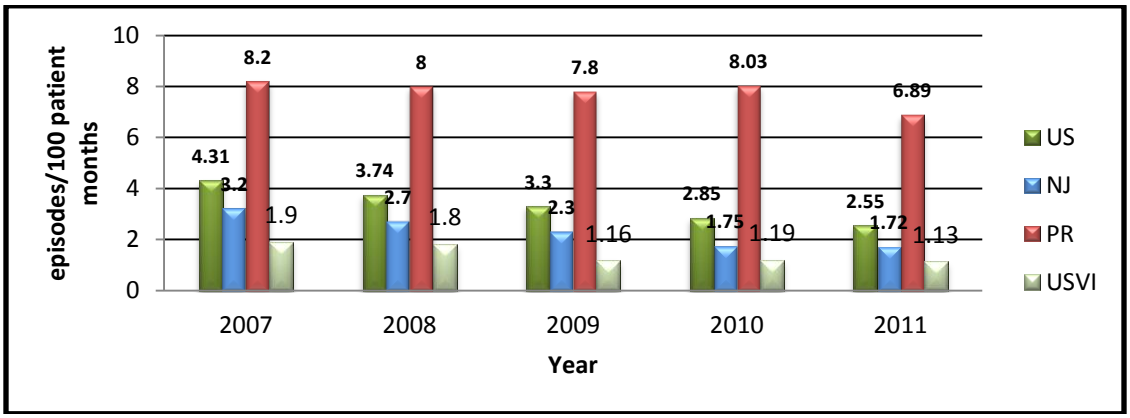
The local SDO has standardized infection control reporting and adopted the QAPI spreadsheet developed by Network 7. Hand hygiene and catheter care audits developed by the CDC Collaborative have been utilized at each facility.

By the end of 2012 96% of Network 3 facilities have registered in NHSN, joined the Network group and are submitting data. The compliance rate for the LDO and SDO facilities in Puerto Rico has been 100%. The LDO hired 5 additional staff to ensure compliance and accuracy. The SDO has one staff member responsible for all reporting.

Outcome

Figure 17 below illustrates the improvement in vascular access infection rates in Puerto Rico in 2011 according to the USRDS Dialysis Facility Report.

Figure 17: Vascular Access Infection Rates by Region 2011*



❖ 2012 USRDS Dialysis Facility Report

As part of this project, all dialysis facilities in Puerto Rico were required to report monthly in NHSN beginning October 2011. By the end of 2012, the Network had 15 months of data to analyze. One of the major clinical practice issues identified was the use of antibiotics without culture verification. This practice has decreased and the overall antibiotic usage decreased by 20%. However, the antibiotic usage varied by ownership; the LDO's antibiotic usage decreased by 30%, the local SDO increased by 25%.

Figure 18 below represents the 2012 data in NHSN. The average vascular access infection rate in all types of accesses measured at 3.1/100 patient months in 2012. The advantage of the NHSN data is the breakdown by vascular access types. Due to the high catheter rate in PR, the catheter infection rate was 8.9/100 patient months in 2012. When compared to New Jersey, (Figure 23) the overall vascular access infection rate in NJ was 0.9/100 patient months and the catheter infection rate was 3.1/100 patient months. The 2013 version of USRDS report is expected to be released on July 15, 2013.

Figure 18: Average Vascular Access Infection Rates in PR 2012

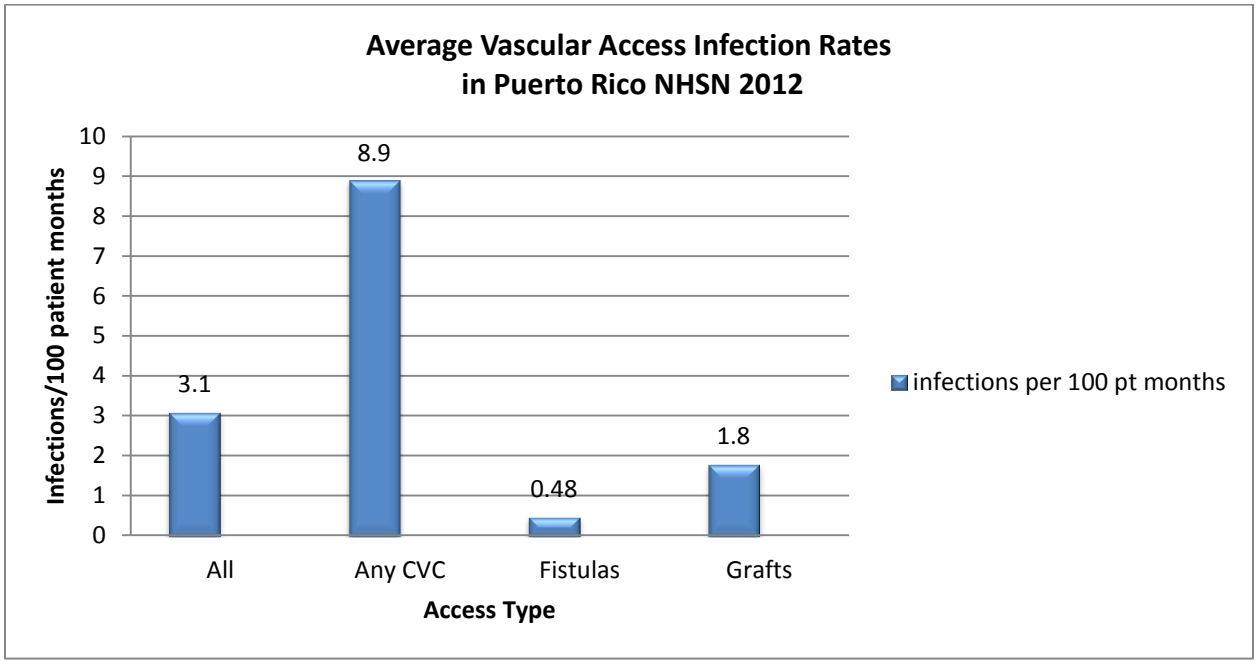
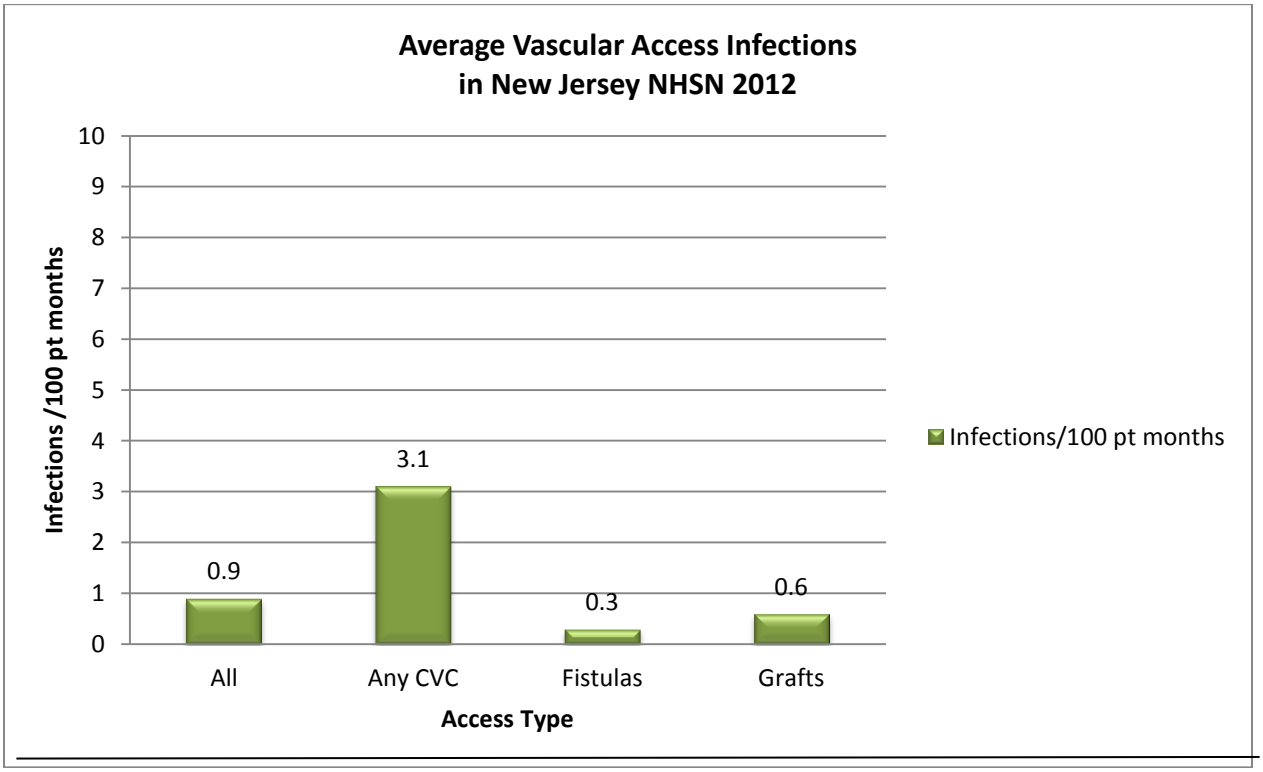


Figure 19: Average Vascular Access Infection Rates in NJ 2012



Vaccination Project

Analyzing data related to health outcomes and working toward the goal of better patient care for End Stage Renal Disease (ESRD) patients are major priorities of the ESRD networks. In its work with Puerto Rico dialysis facilities, Quality Insights Renal Network Three has discovered that the island's providers face many challenges to providing the same quality of care to their ESRD population as providers in New Jersey.

According to the Healthy People 2020 website, "many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen in a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health. It is important to recognize the impact that social determinants have on health outcomes of specific populations".

According to the USDHHS *National Action Plan to Prevent Healthcare-Associated Infections: Roadmap to Elimination for ESRD facilities*, vaccination of staff and patients against influenza and hepatitis B and vaccination of patients against pneumonia are considered priority interventions.

The disparity between Hispanics and non-Hispanics is well documented and remains a national issue. President Obama addressed healthcare disparities in Puerto Rico in his 2008 campaign when he discussed healthcare reform. His plan was to improve Medicare funding, hospital reimbursement, Medicare Part D subsidies and Medicaid in Puerto Rico.

However, data extracted from NHSN shows a substantial disparity in vaccination rates between the predominately Non-Hispanic population in New Jersey (18% Hispanic population according to the 2010 census) and the Hispanic population of Puerto Rico (98% Hispanic).

According to the DHHS Office on Women's Health *2011 Health Disparities Profiles:*
"*Puerto* Rico has among the lowest rates of death for heart disease, cancer, chronic obstructive pulmonary diseases, unintentional injuries and suicide. **However, death rates for diabetes and influenza and pneumonia are among the highest of all jurisdictions presented.**"

Additionally, the 2012 edition of the Statistical Abstract of the United States reported the rate of death from influenza and pneumonia in Puerto Rico is the highest in the nation at 25.6 per 100,000 (2007 data). U.S. Census Bureau (2011). (*Statistical Abstract of the United States: 2012 (131st edition)*. Washington, DC: U.S. Government Printing Office. P92.)

The vaccination project was chosen for several reasons. According to the 2012 USRDS Dialysis Facility Reports, the mortality ratio in Puerto Rico is 59% higher than expected. The ESRD population is at high risk for infection due to a weakened immune system and the increased probability of transmission from close, sustained contact among patients and staff on a weekly basis. An integral part of a plan to reduce infection in a population should be to immunize the at risk population against preventable infections wherever possible. By improving the vaccination rates, the Network hopes to improve the death rate due to influenza and pneumonia in our at risk population, decrease healthcare costs by reducing preventable illnesses and improve the quality of healthcare in the dialysis units.

QIRN3 began this project in September 2012, to enable the Network to increase the influenza vaccination rates during flu season. This project was aligned with the Decreasing Healthcare Associated Infection project, which was started in September 2011, and will continue through the next contract year.

In 2011, the Network Boards established a new goal for Network 3 facilities; facilities are to participate in the CDC, NHSN Dialysis Event reporting module. As part of NHSN dialysis event reporting, QIRN3 facilities were required to complete the CDC Annual Facility Survey during the initial registration process, and then annually. The data collected from these surveys to date included 2010 and 2011 patient vaccination rates for pneumonia and Hepatitis B and staff influenza vaccination rates.

Identified Opportunity for Improvement:

As illustrated in the chart below there was a substantial disparity between the vaccination rates in the Hispanic population in Puerto Rico and the Non-Hispanic populations in New Jersey and the US Virgin Islands.

	2011 (2010 Data)			2012 (2011 Data)		
Vaccination	**PR**	**NJ**	**VI**	**PR**	**NJ**	**VI**
Patient Pneumonia	13.5%	50.1%	51.0%	13.6%	57.5%	53.3%
Patient Hepatitis B	49.3%	67.5%	65.0%	53.9%	65.6%	57.3%
Staff Flu	31.7%	46.5%	34.2%	26.0%	47.3%	25.9%

Project Description:

The people of Puerto Rico welcomed the opportunity to improve infection rates. Over 300 dialysis nurses attended the Network's Annual Meeting in March 2012; this was the largest number of nurses to attend the annual meeting in the Network' history. The entire program focused on infection prevention. On August 21, 2012, Dr. Mario Melgar presented a WebEx in Spanish on the *Importance of Vaccination in the ESRD Population*. The vaccination project was rolled into the infection control initiative and the topic was discussed during the monthly conference calls.

Outcome:

Figure 20: Vaccination Rates in Puerto Rico as of December 2012

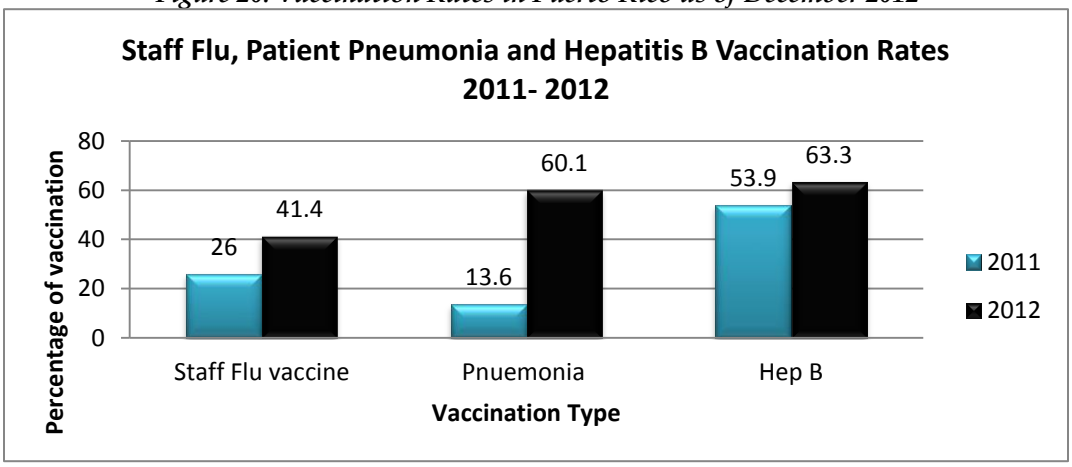


Figure 20 illustrates the dramatic improvement in the pneumonia vaccine. This vaccine was rarely offered to the dialysis patients. The Hepatitis B vaccine rates are more in line with NJ and the US Virgin Islands and the staff vaccine for flu will continue to be monitored through the end of the flu season.

Puerto Rico Healthcare Associated Learning and Action Network (PR HAI LAN)

Network 3 recognized early on that in order to improve the infection rates in Puerto Rico collaboration with other quality organizations was imperative. In March 2012 the first meeting of the PR HAI LAN was held. The first members included; the Caribbean Chapter of American Nephrology Nurses Association, the Puerto Rico Kidney Foundation, the Consejo Renal de Puerto Rico, and LifeLink Foundation, the Puerto Rico Organ Procurement Organization.

During each monthly call, current members identified new members who were recruited and joined. By the end of 2012 the partnership grew to 21 members. For the first time in Network history the two largest dialysis providers in Puerto Rico are working together on the same project. Members have participated in educational programs of other quality organizations throughout the Island. Members, through their own organization have been provided educational programs for physicians and nurses.

The members include:

Members Name	Organization
Marien Saade	QIRN3 Medical Review Board Member, LifeLink Foundation, ANNA
Jeannette Dominquez	Puerto Rico Kidney Foundation
Rita DeJesus	ANNA Chapter President
Jose Cangiano, MD	

Accomplishments:

a. The Puerto Rico Kidney Foundation provided an all-day education program for dialysis patients. Over 500 patients and family members listened to speakers discuss ways to reduce the risk of infection in the dialysis patient.
b. La Sociedad de Nefrología e Hipertensión de Puerto Rico provided an all-day education program for 60 physicians. Dr. Matt Arduino, from the CDC discussed Multidrug Resistant Organisms and Infection Prevention in the Dialysis Unit.
c. The ANNA Caribbean Chapter provided an all-day education program for over 125 dialysis nurses on infection prevention
d. The LAN developed a Spanish version of the WAVE Campaign which was developed by the Office of Healthcare Quality and the USDHHS Partnership for Patients. The campaign encourages patients to protect their loved ones by **W**ashing hands, **A**sk questions, **V**accinate against flu and pnuemonia and **E**nsure safety. The Spanish version was **VELA**. The LAN organized a contest for dialysis facilities to compete for the best facility project to decrease healthcare associated infections. The winner will be announced at the November 2013 Educational program that will be co-sponsored by the PR HAI LAN and QIRN3.
e. The LAN members are working on developing a poster about catheter care at home. The plan is to distribute the poster to all dialysis facilities and nephrologists' offices.

Task 1.d. Facility Specific Quality Assessment and Improvement

For this task, facility-specific quality improvement activities are implemented with a specific facility or a group of facilities. The Network maintains the capacity to respond to local needs upon the request of facilities, CMS, SSAs or in the event of identification of problems or poor performances during site visits. A review of complaints and grievances may trigger a facility specific project and analysis of clinical outcomes identifies the lower performing facilities. Quality Assessment and Improvement Projects (QAPIs) are conducted when these situations are identified.

a. Provide Quality Oversight to Ensure Patient Safety - 3 U.S. Virgin Island Facilities

In 2012, NW3 continued to provide quality oversight at the three Virgin Island facilities at the request of CMS to assist the dialysis facilities to achieve and sustain compliance with the Federal Conditions for Coverage. Based on this identified need an action plan was developed in collaboration with the CMS ESRD Technical Lead for the Northeast Division, with the full cooperation of the New York Regional Office of CMS to address the specific needs of each facility.

Project Description

At the request of CMS in 2007, the Network began to monitor patient safety and quality of care issues related to infection control, water treatment, equipment maintenance, medication administration, patient assessment and plan of care at the three Virgin Island facilities. The facilities were required to provide the network with monthly data and patient records to address each specific area. Network QI staff reviewed this information and monitored implementation of recommended changes by the facilities to improve their outcomes. This project has been extensive and has continued for several years. It involves ongoing communication between CMS, Network staff and facility leadership through monthly conference calls, emails, on-site visits and record review.

There are some critical issues that afflict the US Virgin Islands and make the dialysis providers in this area special. The cost of providing dialysis services is much higher than on the US mainland. Shipment costs are almost as expensive as the cost of the supplies. The cost of electricity is 7-8 times more expensive than Stateside. Water is provided through cisterns, which contain a mix of rain and municipal water. In 2011 the primary employer for the islands closed its doors and the unemployment rate is expected to reach 20%. Supplies are often held up at customs even though they are coming directly from the US. It can sometimes take 2-3 weeks for an order to arrive from the States. The local government often impedes the hiring of qualified staff; the facilities are primarily staffed with hiring traveling nurses. Crime is an issue; so 4th shift options are not feasible. Public transportation is limited and like in the States is not available at all hours. The option of closing a facility is limited; at the time of this report there is only one facility on St. Thomas and neither facility on St. Croix can accommodate all the patients if one of the two facilities was to close.

In 2011, the hospital-based program on St. Croix (Governor Juan Luis Hospital) was placed under a Systems Improvement Settlement Agreement (SISA) and was mandated by CMS to hire an interim management (IM) team. The IM team began onsite in January 2011 and has sustained substantial improvement over the last 24 months. Most clinical indicators met or exceeded Network goals. Vascular access placement issues related to surgeons, reported earlier in this document, continue to plague goal achievement. The IM team has developed a strong performance improvement program but has been unable to completely pass control to the leadership staff, although this has improved during 2012. A major struggle for the IM team has been to provide a stable leadership workforce. The nurse manager and assistant nurse manager roles have been stable but the head nurses contract is due to expire in June 2013. Monthly conference calls with the CMS ESRD Technical Lead for the Northeast Division, the New York Regional Office of CMS and Network staffs were decreased to bi-monthly at the end of 2012. The ability for the hospital to sustain improvement once the SISA is terminated is a serious concern. Monthly data submission is still required and reviewed by Network staff.

The second independent facility on St. Croix (Caribbean Kidney Center) has demonstrated sustained improvement. Bi-monthly calls continue with this facility, the CMS ESRD Technical Lead for the Northeast Division, the New York Regional Office of CMS and Network staffs. Monthly data submission has continued throughout the last 4 years.

The hospital-based facility on St. Thomas (Roy Lester Schneider Hospital) was not surveyed during 2012, but continues to conduct bi-monthly conference calls with CMS, the NW and the NYRO. Monthly data submission continued and they have demonstrated sustained improvement. Stability in the leadership staff has been key to their success. The consultant mandated by CMS approximately 3 years ago continues to provide guidance. This facility has two major issues:

1. They are reaching maximum utilization and lack the financial resources to expand
2. The majority of the nursing staff is comprised of traveling nurses and they lack the resources to establish local educational programs

The facility is working with the hospital administration and local government to find funding to expand to meet the growing need. The sudden growth in the number of prevalent patients may be related to the improved clinical outcomes seen over the last 3 years.

5 Diamond Patient Safety Project

In 2010, Network 3 launched the 5 Diamond Patient Safety Program developed by Networks 5 and 1 to the staff of New Jersey, Puerto Rico and the US Virgin Island dialysis facilities at the Annual Educational Programs.

The modules were used by dialysis providers as a template for in-service training for dialysis staff and patients. The purpose of this voluntary project was to provide dialysis providers with dialysis specific staff educational modules on different safety topics. Providers registered with NW3 to participate in the program and selected from 13 safety modules to complete. The modules include the tools and training resources necessary for implementation of each patient safety concept. Facilities chose to complete as many or as few modules as they wish, with only one component, Patient Safety Principles, being mandatory. As each module was completed, the provider submitted a reporting form and evidence of the required activities to the Network, which reviewed the submission for completion according to the program standards and acknowledged finished activities with a certificate and listing on the NW3 website. NW 3 also facilitated the submission of the *Constant Site Cannulation* Module which was created by one of the NW 3 facilities as a project and accepted for inclusion in the 5 Diamond program module set.

NW 3 decided to stop participating in the 5 diamond program in September 2012 after two years of activity but has continued to recommend that facilities utilize the resources available on the website for patient and staff education. At program's end, seventy-seven of NW3's one hundred sixty-five facilities participated in the program. Forty attained 5 Diamond status. One was 4 Diamond, three were 3 Diamond, thirty-one earned 2 Diamond and two earned 1 Diamond status.

B. Improve the independence, quality of life, and rehabilitation (to the extent possible) of individuals with ESRD through transplantation, use of self-care modalities, as medically appropriate, through the end of life.

Supportive Activities

Network 3 continues to promote independence, quality of life, and rehabilitation through various activities, as outlined below. The Network has encouraged participation in vocational rehabilitation through the promotion and distribution of patient educational materials through emails and mailings, during facility visits, patient education programs, newsletters, the Network web site and various provider meetings throughout the year.

Patient Advisory Committee Newsletter

The Patient Advisory Committee (PAC) produced and distributed the ***Kidneys R Us*** newsletter quarterly with assistance and contributions from the PAC members, dialysis providers and Network staff. The newsletters were translated into Spanish and distributed to all the Network facilities. Content included: Maintaining Your Lifeline (Vascular Access); Medicare and ESRD; Buttonhole Cannulation; Hand Hygiene; Albumin; Eat Right to Feel Right; Living a Full Life While on Dialysis; Holiday Desserts and Understanding the QIP. Information about the Network, the patient's toll-free number, the web site address and information on joining the PAC were included in every newsletter.


Quality Insights Renal Network 3

KIDNEYS R US

FROM THE QIRN3 PATIENT ADVISORY COMMITTEE

UNDERSTANDING THE NEW MEDICARE RULES ABOUT DIALYSIS SERVICES AND PAYMENTS

Web Site

The Network's web site (http://www.qirn3.org) provides information about Network 3, as well as educational and resource materials in English and Spanish. The Web site was developed to serve patients and their families, dialysis and transplant providers, and the community at large. The Web site includes information on:

- Conditions for Coverage
- Annual Reports
- 5 Diamond Program
- Quality Improvement Projects
- Performance Measures
- End-of-Life
- Involuntary Discharge
- Nutrition
- Patient – Provider Conflict
- Patient Safety
- Transplantation

- Vascular Access
- Dialysis Facility Compare
- Emergency/Disaster Preparedness
- Data
- Continuing Education
- Web Ex Training
- Patient Advisory Committee
- Medicare
- Vocational Rehabilitation
- Complaints and Grievances
- FAQs
- Rights & Responsibilities
- Patient Newsletters

The Web site has a "Search" feature that allows the viewer to search within the site itself. The site meets Federal Section 508 accessibility requirements and is updated with new content on a regular basis. The "Contact Us" feature allows the viewer to contact a Network 3 staff member with questions or requests for additional information.

Vocational Rehabilitation

Network 3 processed 75 calls from patients and providers during CY2012 with questions concerning financial or reimbursement concerns, loss of benefits and requests for educational materials and resources. Patients received individualized vocational counseling on the benefits of exercise**,** transplantation**,** home dialysis options and training requirements for home dialysis.

Facility social workers were given information to help their patients address rehabilitation concerns, apply for disability, Medicaid and/or Medicare, Social Security benefits, obtain medications and Medicare Part D, apply for secondary insurance, join patient support groups, financial assistance programs and educational scholarships.

The Network promotes the participation of patients, providers of services and ESRD facilities in vocational rehabilitation. Facilities are required to post in a prominent place the Network poster describing treatment modalities, the Patient's Rights and Responsibilities, and the patient complaint brochure titled *I Am a Dialysis Patient, What Can I Do If I Have a Complaint?*. Facilities are encouraged to provide treatment schedules that allow patients to work or refer patients to another facility with this ability.

Annually, at the Network education program the Ahmet Ahmet Rehabilitation Award is presented to a dialysis patient who was nominated by his/her dialysis facility for exemplary behavior as an individual who through rehabilitation has overcome the many challenges of dialysis and best embodies the spirit of rehabilitation.

The Network provided several vocational rehabilitation education programs during CY2012, they are listed below:

- On April 10, the Network participated in the University of Pennsylvania Transplant Program held in Philadelphia. The Network presented on the role of the transplant designee in NW3.

Over 100 participants attended this program and many of these attendees work for dialysis facilities in New Jersey.

- On April 19, the 22th Annual Transplant Designee program was held in central New Jersey by the Network in collaboration with the Saint Barnabas Healthcare Kidney and Pancreas Transplant Program. The Network has over 300 certified transplant designees in New Jersey after completion of this program. These designees are asked to work with dialysis patients to get listed for transplant. The goal of transplant is to improve the quality of life of the renal patient and allow for the return to employment, education and volunteerism.
- On April 24, the Network hosted a webinar for social workers on Medicare and ESRD. This was designed to educate social workers about the Medicare program and the coordination of benefits with Medicare and Employer Group Health Plans. Social workers trained in this topic will be able to educate patients who are employed as to their insurance options to help them make decisions on maintaining their employment.
- On June 28, the Network hosted the annual Home Designee webinar that outlined the options for home dialysis for patients. This was presented to staff at facilities who were interested in being the home designee at their facility. This program is designed to ensure that all patients learn about their home dialysis options. These options will allow for dialysis and work scheduling to occur without the restrictions of an out-patient hemodialysis schedule. Patient vocational rehabilitation with return to employment is one of the benefits of home dialysis.
- On October 4, the Network held its Annual Meeting. Topics included: The Future of Fistula First; Patient-Centered Care; Acceptance and Commitment Therapy with the Dialysis Patient; Improving Adherence Through Innovative Teaching and Motivational Interviewing: Reaching the Patient on Dialysis . The program was attended by over 400 physicians, patients, administrators, nurses, dietitians and social workers. Increasing patient quality of life will enable many patients to consider returning to active employment, education and volunteerism.
- Annually, the Network provides the social workers with the list of rehabilitation centers from the Division of Vocational Rehabilitation Services for New Jersey, Puerto Rico and the U.S. Virgin Islands.
- The NW sends emails from Social Security to Social Workers to promote the “Ticket to Work” webinars. The social workers are encouraged to provide the information to any patients on SSD who may be interested in returning to employment.

C. Improve patient perception of care and experience of care and resolve patient complaints and grievances

Network 3 worked consistently during CY2012 to ensure that all patients' complaints and grievances were investigated and resolved in a timely manner. The Network required each facility to post in a prominent place NW3's Rights and Responsibilities and distribute paper copies provided by Network staff on an annual basis. Each facility must fully document all involuntary discharges and notify NW3 of each occurrence as required in the Conditions for Coverage.

Supportive Activities

The Patient Rights and Responsibilities and Complaint Brochure were distributed to all facilities in English and Spanish. Facilities were asked to display the material in a prominent place such as the waiting room, and distribute paper copies provided to all patients. In addition to paper copies, NW3 Rights and Responsibilities and Complaint Brochure are posted on the web site in English and Spanish. When a new facility was approved by CMS as an ESRD provider, a package of materials was sent which contained the above mentioned documents.

The patient education brochure titled *I Am a Kidney Patient What Can I Do If I Have a Complaint?* describes in basic terms the complaint process and how to contact NW3. The brochure was provided in both English and Spanish and distributed to all facilities in 2012. All facilities were required to get patients' signatures verifying they received the brochures. The signature sheets were then faxed back to the Network as verification of the distribution. One hundred percent of facilities provided NW3 with signature sheets.

This was the fourth consecutive year that NW3 utilized this strategy to ensure patients were receiving the brochure that was sent to the facility. The NW tracked the number of beneficiary complaints that were received in the two months following distribution for all four years; 2009, 2010, 2011 and 2012. In 2012, the brochures were sent out in October. The NW received eleven complaint calls in November and December. In the two prior months, August and September, there were also eleven complaint calls received. In each of the previous years, the number of calls increased following distribution of the complaint brochure. This strategy will be monitored again in 2013 to see if the impact has lessened over the years and the strategy is no longer effective.

Additionally, NW3 promoted an increase in beneficiary awareness of Network functions and responsibilities through patient education programs; the Patient Advisory Committee newsletter: *Kidneys R Us;* and the poster titled *Did You Know* which provides information on NW3 and the contact information which is a required posting at all facilities.

Evaluate and Resolve Patient Complaints and Grievances

NW3 may receive a written or oral complaint or grievance from a dialysis patient, patient representative, family member, friend, or others concerning either dialysis or transplant providers.

Referrals of ESRD consumer complaints or other concerns may be received from professional review organizations, state agencies, Medicare hotline numbers and Medicare intermediaries. When an oral grievance is received, the person taking the grievance will usually ask the consumer to document it in writing. During complaint or grievance investigations, consumers may designate representatives to act on their behalf. Immediate investigation is started for a potentially life-threatening issue. NW3 had three formal grievances in CY2012. The Network investigated ninety complaints in CY2012; fifty

were for treatment related/quality of care issues. Staff related and physical environment were the next most commonly cited reasons for complaints with thirty-eight and twenty-two respectively.

Consumers were encouraged to use facility internal processes prior to referring a complaint or grievance to NW3 because local problem solving can preclude escalation to a more serious level. When a patient did not wish to use the facility process (it is not mandatory that consumers use the facility grievance process), they contacted NW3 for assistance.

The Network's responsibility for complaints/grievances is to review issues raised and determine the required action (i.e., investigation or referral). Consumers were asked to provide permission to Network staff to contact facilities for investigation of the complaint. Attempts were made to resolve complaints by acting as an investigator, facilitator, referral agent, or coordinator between a patient and the provider.

Quarterly, NW3 reviewed and analyzed contact information at internal quality improvement meetings. Data was evaluated for trends and interventions were formulated and discussed with the Patient Advisory Committee and Boards, if indicated. Involuntary discharges continue to be examined to determine if any patterns or trends exist. In 2012, NW3 handled nine involuntary discharges that did not involve facility closures. Of these nine, six were immediate discharges resulting from a severe and imminent threat and three were for ongoing abusive behavior.

The NW also tracked thirty-three involuntary discharges that were related to insurance changes in Puerto Rico that resulted in patients being required to leave the Atlantis facility they were at and transfer to a Fresenius (FMC) facility. These patients were in a Medicare Advantage Plan and their Atlantis provider was dropped by Medical Card Systems (MCS) as an in-network provider. After several months of patient discontent and intervention by a Public Advocate on the Island, the decision to move current patients was rescinded and only newly diagnosed patients would be required to go to FMC. The patients who transferred out were required to contact MCS about returning to their Atlantis facility.

Ninety-eight patients were involuntarily discharged from FMC Hoboken due to facility closure following flooding from Hurricane Sandy. These patients were all directly transferred to other FMC clinics without interruption in service. FMC will transfer patients back to Hoboken after the facility is renovated to repair the storm related damage.

Eighteen patients were involuntarily discharged from Caguas Nephrology Unit due to facility closure. These patients were transferred to Atlantis and FMC facilities on the Island.

The NW also tracked fifty-two involuntary discharges of patients from FMC St. Michael's Medical Center. These discharges were the result of a facility closure. All patients were directly transferred to other units in the area.

NW3 staff worked with facility leadership to avoid involuntary discharge and recommended the use of the Dialysis Patient Provider Conflict Resolution Tool Kit when the discharge was related to abusive or disruptive behavior of a patient or family member. All facilities were encouraged to work with patients who are at risk for involuntary discharge to help modify their behavior enabling them to remain in the facility.

Patient Advisory Committee

The Patient Advisory Committee consists of patients from dialysis facilities in NW3's area and represents all modalities. Members have a genuine concern for quality of care issues. The committee serves as a link between patients and the Network, and encourages patients to be involved in their healthcare, share skills, knowledge and experience.

The committee supported NW3's mission to improve the quality of care provided to patients and represented the entire patient population. The committee provided consumer advice to the Medical Review Board and the Board of Directors. The members were involved in creating the patient newsletter, *Kidneys R Us*, and assisted with the development and promotion of educational materials and resources for patients.

In 2012, the committee developed, reviewed and organized the content for the newsletter, which was distributed in March, June, September and December. The newsletters were translated into Spanish and distributed to all the Network facilities. Content included: Maintaining Your Lifeline (Vascular Access); Medicare and ESRD; Buttonhole Cannulation; Hand Hygiene; Albumin; Eat Right to Feel Right; Living a Full Life While on Dialysis; Holiday Desserts and Understanding the QIP. Information about the Network, the patient's toll-free number, the web site address and information on joining the PAC were included in every newsletter.

The Patient Advisory Committee continued to add new members who are acting as Patient Representatives for their facilities. These patients attend the meetings by conference call or in person when possible. Their role is to participate on the committee with the same responsibilities as the PAC members without the expectation they will attend meetings in person. At the end of 2012, one hundred patients had signed up to be Patient Representatives for their facilities. Meetings were held quarterly at a location in central New Jersey. Conference calling was utilized during each meeting.

D. Improve collaboration with providers and facilities to ensure achievement of goals A through C through the most efficient and effective means possible, with recognition of the differences among providers and associated possibilities/capabilities.

Establish and Improve Partnerships and Cooperative Activities

CMS encourages Networks to establish and enhance partnerships with other health agencies and groups. The Network collaborated with CMS regional offices, state survey agencies, New Jersey and Puerto Rico Departments of Health, quality improvement organizations, the New Jersey Renal Administrators Association, American Nephrology Nurses Association (ANNA), Council of Nephrology Social Workers, APIC, the CDC and interested agencies as reported throughout this document to improve the quality of care provided to consumers.

State Survey and Certification Agencies

The Network collaborated with the State Survey agencies in New Jersey and Puerto Rico. Health and safety problems and complaints were referred to the appropriate state agency for investigation and resolution. The Network held monthly telephone conferences with the CMS Contracting Officer Representative for the Northeast Division, the New York Regional Office and state surveyors in New Jersey and Puerto Rico.

The Network collaborated with the State surveyors to establish a communication process to provide State surveyors with clinical and consumer complaint data utilized during routine or re-certification surveys. A tool was completed by Network staff prior to a scheduled State or Federal survey. The tool included vascular access data, QIP results, phosphorus reports, Elab reports on clinical performance measures and related quality improvement plans. The Network reported facility specific complaints and grievances and involuntary discharges. The data sharing supported focused intervention by the State surveyors and may have resulted in improved outcomes due to collaborative efforts by the NW and State Survey Agencies.

A program of educational activities shared by the Network and State surveyors was implemented for 2012. A total of 6 programs were held and topics include: hemodialysis hands-on training, NHSN registration; prioritizing surveys, Bridging the Communication Gap, reporting disasters and transplantation.

The Network Council

For decades Network 3 held the Annual Renal Council Meeting and sought the input of providers, consumers and renal professionals attending the meeting. In an effort to increase communication and collaboration with the providers and consumers the Network Council was reorganized in 2009. The Network Council served as a liaison between its provider membership and the Network, which included renal providers and transplant facilities, and represented various geographic locations and types of professionals working for facilities in the area. Volunteers for the council were sought via email and during Network meetings. The first New Jersey conference call was held on December 15, 2009 with 21 attendees, including one patient from the PAC committee.

In July 2011, the Network Council developed into two Network Councils: one to address the needs of New Jersey and the US Virgin Islands, the other to address the specific needs of Puerto Rico.

The NJ and USVI Network Council conference calls were held on the following dates:

- January 5, 2012 with 97 attendees,
- April 3, 2012 with 87 attendees,
- July 5, 2012 with 54 attendees,
- October 2, 2012 with 53 attendees

The PR Network Council conference calls were held on the following dates:

- January 12, 2012 with 34 attendees
- April 10, 2012 with 44 attendees
- July 12, 2012 with 35 attendees
- October 9, 2012 with 39 attendees

The Network provided the Council members with the quarterly conference call schedule from July 2012 through to October 2013 with alternating Tuesdays and Thursdays and alternating times at 10 AM and 2 PM, per members' request.

Prior to each call, the agenda and meeting minutes were distributed to the Council members. Topics discussed have included:

- Webinars
- Local issues/concerns
- Educational needs
- Suggestions for annual meeting, including RD and SW breakout sessions

- Patient and Professional Education programs
- Preparation and lessons learned during hurricane season and other severe weather events
- Infection Control Concerns and NHSN
- 5 Diamond Patient Safety Program
- Dialysis Facility Report and ESRD Quality Incentive Program
- Topics for the monthly patient education fact sheets
- Patient lobby days

New Jersey Renal Coalition

In March 2005, CMS introduced the Strategic Partnership for Change initiative to ESRD Networks. The goal of the program was to …*ensure optimum quality of care along the continuum of Chronic Kidney Disease (CKD/ESRD) and End Stage Renal Disease by using coalition and partnership building as strategic tools.* The coalition structure and mission were introduced to the Network's renal community.

The New Jersey Renal Coalition (NJRC) mission states that it will provide a multifaceted approach to improve patient education and professional clinical practice patterns for the pre-ESRD and prevalent dialysis patients. Members included nursing administrators, insurance carriers, the New Jersey Department of Health, New Jersey Healthcare Quality Strategies Organization, American Nephrology Nurses Association, American Dietetic Association, patients, a nephrologist, nurses, social workers, dietitians, PharmDs, transplant coordinators, New Jersey Hospital Association, social workers, the Renal Support Network and other interested groups. The coalition meets at least quarterly in person and/or by conference call if members are unable to attend in person.

The Coalition goal is to enhance the quality of care provided to patients with CKD and ESRD through the provision of professional and community education and increased awareness.

In 2012 the NJRC collaborated with the Patient Advisory Committee (PAC), the National Kidney Foundation, Holy Name Medical Center, Saint Barnabas Medical Center, Newark Beth Israel Medical Center and the Saint Barnabas Renal and Pancreas Transplant Division to develop educational programs for patients and professionals. The following programs were sponsored by the Coalition:

During 2012 the Coalition achieved the following:

- In May 2012 distributed a Medical Director Report Card focusing on reporting measures to meet the Network goal for decreasing catheters greater than 90 days and to meet the Network-defined AVF goal specific to each dialysis facility.
- The Coalition provided a professional program on March 22, 2012 at Saint Barnabas Medical Center on CKD, *Chronic Kidney Disease, A Mini Symposium.* The program included the following topics: An Overview of CKD Diagnosis and ESRD, Sodium and Blood Pressure Control in Dialysis, Vascular Access, Anemia, Transplantation, CKD in Children and a panel discussion. The coalition obtained 3.5 educational contact hours for participating MDs, nurses and dialysis technicians.
- The patient education program, *"What you Need to Know About Kidney Transplant"* was held on May 10, 2012 at the Leon and Toby Cooperman JCC MetroWest in West Orange, NJ . The program was co-sponsored with the Renal and Pancreas Transplant Center at Saint Barnabas Medical Center.

- The program, "*Chronic Kidney Disease Symposium*" was held on October 26, 2012 at Newark Beth Israel Medical Center. The program was tailored for physicians, nurses and other kidney disease professionals. Topics included: Early Recognition of CKD, Risk Factors in CKD, Co-morbid Conditions, Cardiovascular Disease and the Team Approach to Management of CKD Progression. The coalition obtained 3.5 educational contact hours for the MDs, nurses, RD's and SW's.
- The Coalition collaborated with Holy Name Medical Center and the NKF to provide a workshop for patients to learn about the transplantation and living donation process on September 13, 2012. The topics included: Living and Deceased Donor Transplantation, Medications, Financial Implications of Transplant and Recipient Perspectives.

Medical Director Report Cards

Since 2006, the coalition has distributed the quarterly vascular access Medical Director Report Card to all dialysis facilities in New Jersey. The report ranked the facility within the state by prevalent fistula and catheter rates. In 2011, the New Jersey Renal Coalition revised the Medical Director Report Card. The Report was changed to provide metrics for facilities to meet the Network goals for decreasing catheters greater than 90 days and Network defined facility specific AVF goals.

The report included:

- "To Do List" to decrease the catheter rate
- 2014 QIP measures that will be based on 2012 data.
- Encouragement for the Medical Director to examine the facility practice patterns and decrease the percentage of catheters used
- State ranking for fistulae and catheter rates
- Quarterly comparison data

In addition, the report provided the physician with the number of patients with a catheter the facility had to remove to meet the Network-defined goal for catheters greater than 90 days. The number of AVFs that needed to be placed to meet the Network-defined goal for AVFs was also included. Each report contained a reminder of the FFBI Change Concepts.

The first quarter 2012 Medical Director report was mailed to facility medical directors in May 2012. June of 2012 was the beginning of CROWNWeb data reporting for facilities and due to the volume of data requiring submission and the extension of the deadlines for facilities to enter their data, no reliable data was available to send to Medical directors for the remaining quarters of 2012.

Emergency/Disaster Preparedness and Response

In 2012, Network staff participated on the national Kidney Community Emergency Response Coalition (KCER) pandemic response team. Conference calls were attended to add input into the planning for potential pandemic emergencies. The Network also participated on the NJ Group for Access and Integration Needs in Emergencies and Disasters (NJGAINED), formerly known as the Special Needs Advisory Panel (SNAP). This group is run by the NJ Office of Emergency Management (OEM). Participation on this coalition is vital to ensuring that the needs of the dialysis patients in NJ are considered by all local, county and state emergency planners as they develop their strategies for dealing with various emergencies that could impact the state.

In October 2012, Super Storm Sandy had a major impact on NW3. The storm arrived on Sunday, October 28 bringing strong winds and rain. The dialysis facilities had been aware of the impending storm through emails from the NW of weather briefings from NOAA's National Weather Service. Facilities

were encouraged to adjust schedules to get patients in for treatments on Sunday, October 28 before the brunt of the storm hit NJ on Monday, October 29 and Tuesday, October 30. Many facilities in NJ opted to open on Sunday to allow the facility to close on Tuesday. This strategy proved helpful as the state had tremendous damage from the Super Storm that resulted in road closures, power outages and flooding.

The NJ Department of Health regulations for dialysis facilities require back-up generators to be placed at the facilities. This was extremely helpful as it allowed the thirty-five facilities that were without power following the storm to remain open. One facility, FMC Hoboken, closed following the storm as it received significant flooding. The ninety-eight patients who were discharged were admitted to other FMC facilities in the north Jersey area. This facility remained closed at the end of 2012.

The NW communicated with facilities in the days following the storm to determine the status of operations. The NW office was without telephone or widespread internet service for three days after the storm. Staff worked from home on Sunday, October 29 and Monday, October 30. NW staff that were able to travel reported to the office on Tuesday, October 31. They utilized cell phones and an emergency cable line for email access to one computer. The NW staff were able to communicate with the NJ facilities to keep track of all facility closures, fuel problems, generator issues, and displaced patients. This information was communicated to CMS and KCER during follow-up conference calls arranged by KCER.

The information on all facility closures was added to the website: www.dialysisunits.com by the NW to ensure the facility status was available to patients and providers to locate as needed. Information was updated on the website as circumstances changed.

Ongoing communication between the NW and dialysis facilities and the NW and emergency providers is the focus of emergency/disaster planning. The dissemination of information to facilities in anticipation of weather related emergencies and natural disasters is crucial to the NW goal of minimizing the impact of such events on renal patients. The ongoing relationship with national, state, county and municipal emergency planners helps to facilitate this type of communication.

Professional Organizations

The Network participated in the planning of the Transplant Designee conferences held in New Jersey and Pennsylvania. The programs were developed in collaboration with the Saint Barnabas Kidney and Pancreas Transplant Program on April 19, 2012 and with the Penn Transplant Institute – Kidney Transplant Program Annual Nursing Symposium for Dialysis and Nephrology Nurses, University of Pennsylvania on April 10, 2012.

The Network conducted activities with the American Nephrology Nurses Association (ANNA) both nationally and with local chapters. ANNA provides the contact hours for the Network education program. Network staff displayed outcome data and provided resource handouts at several local chapter meetings.

The Network collaborated with the Puerto Rico Kidney Foundation, the Consejo Renal, the Puerto Rico Society of Nephrology and Hypertension, ANNA Caribbean Chapter, LifeLink Foundation, Auxilio Mutuo Hospital, Fresenius Puerto Rico, Atlantis Healthcare, the Veteran's Administration in Puerto Rico and a patient representative on the development of a Learning and Action Network to provide consumer and professional education on decreasing healthcare associated infections. The first face-to-face meeting was held February 28, 2012.

Annual Network Education Programs

On October 4, 2012, the Network held the Quality Insights Renal Network 3 (QIRN3) Annual Education Program. Approximately 450 dietitians, social workers, physicians, nurses, patients and family attended the meeting. Guest speakers included:

- Cliff Sales, MD, "*The Future of Fistula First*"
- Karen Curtiss, Founder Campaign Zero "*Campaign Zero*"
- Alicia Cole, Patient "*Alliance for Safety Awareness for Patients*"
- Elena Balovlenkov, MS, RN, CHN, Center for Medicare &Medicaid Services "*Patient Centered Care*"
- Toros Kapoian, MD "*QIP -Are You Ready?"*

Afternoon breakout sessions for social workers and dietitians included:

Social Workers

- Mark Meier, MSW, LCSW, "*Depression in CKD-The Time to Act Is Now*"
- Mary Rzeszut, MSW, LCSW, "*The Use of Acceptance and Commitment Therapy With hemodialysis Patients*"

Dietitians

- Tara Sherman, RD, CSR, CDN, "*Improving Adherence Through Innovative Teaching*"
- Dawn Berry, RD, CSR, CDN, LD, CNSC, "*Motivational Interviewing: Reaching the Patient On Dialysis.*"

The program also included the presentation of the Ahmet Ahmet Rehabilitation Award to a consumer elected by the Boards from the many deserving nominations submitted by facility staff, and was a meeting highlight.

The dialysis facility staff were invited to feature specific internal quality projects for the benefit of all meeting participants. Fifteen posters were displayed at the 2012 annual meeting:

Atlantic Artificial Kidney Center
Reduction in Catheter Rates
Linda Scrimer RN, BOM, Wendy Wehrent, Krystal Reid, CCHT

Atlanticare Regional Medical Center
Positive Deviance: Dialysis Best Practice for Improving Quality and Creating a Culture Change
Erin Jones, RN, BSN Pamela M. Peterson, RN, BSN, MBA, NE-BC
Mary Downs, LPN, Kate Lemaire, RN, Evalyn Marshall, Robin Blackwell
Booker Outpatient Dialysis at Riverview MC
Adequate Dialysis
Vimla Christian, RN, CNN,

DaVita Burlington North
Facts about Missed Dialysis Treatments
Urszula Les, MSW, LSW, Pattie James, RN, BSN, Lourdes Rodriguez, RN
Cristy Elbrecht

DaVita Holmdel
Phospho-Derby

Karen Wood, RN, MSN, Arlene DeMarco, RD
Joanne Doremy, RN, Dawn LaGrippo, MSW

Dialysis Associates of Northern New Jersey
Travel and the Renal Patient
Meryl DeLuca, MSW, LSW, Barbara Miller, RN

East Orange General Hospital
Interdisciplinary Act (IDA)
Padmaja Kodali, MD Kenneth Brown, MSN, RN, CNN
Mariam George, MPA, RN, CNN, Esther Adesina, MS, RD
Nella Kigel, MS, RD, Mary Anne Lund, MSW, LCSW
Qiying Zhou, MSW, ACSW

Fresenius Hoboken and Harrison
A step by step guide to obtain Renvella utilizing the Renassist Assistance Program
Anita C. Kahan, MSW, LSW

FMC Kenvil
PD Home Therapies
Donna Buglisi, BSN, RN, CNN, Shan-Li Chen R.D. MBA
Barbara Tepper, MSW

Kidney Center at Millville
Most Concerned About Nutrition Topics for the New Hemodialysis Patient
Amy Kaminski, RD

Kidney Life, LLC
Phosphorus
Nidia Garcia, RN

Liberty Dialysis -New Jersey
Improving Adherence And Team Morale Through Fun Patient Activities
Eleanor Witkowski, MSW, LSW, Jennifer Geiger, MSW, LSW, NSW-C,
Lisa Abbott, RD

Renal Ventures Bayonne
Treatment Compliance
Rosario Bernales, RD, Elvie Delos Santos, RN,BSN
Elizabeth Soriano, RN, BSN, Patricia Hathcock, MSW,
LCSW, Shirley Pino

Trinitas Regional Medical Center – Renal Services
Improvement in Anemia Management Outcomes of the ESRD patient through interdisciplinary developed protocols and evidence based practice
Joseph McTernan, MBA, Dr. James McAnally, MD
Chrissy Schabacker, PharmD, Donna Dachuna, RN
Sharon Washington, RN, Joan Hoffman MS, RN
Diane Reehil, ANP, RN

Annual Puerto Rico Education Program

On March 4, 2012, the Network held the Quality Insights Renal Network 3 (QIRN3) Annual Puerto Rico Education Program. Approximately 300 administrators, nurses and physicians attended the meeting which was conducted in Spanish and focused on infection control in the dialysis unit. Guest speakers included Pedro Vergne-Marini, MD, "*Infection Control Statistical Overview*", Lourdes Cruz, MSN, RN who discussed the "*Most Frequently Cited Infection Control Deficiencies*", and Mario Melgar, MD who presented *"A Guide to the Elimination of Infections In Hemodialysis"* and *Infection Control In Dialysis: Basic Measures"*. The final presentation was by Dr. Neil Gupta who spoke about "*Preventing Bloodstream Infections in Hemodialysis*".

The attendees strongly agreed that the program was well organized and relevant to their practice. The program evaluations indicated that the speakers were knowledgeable of their subject, objectives were relevant to the overall purpose of the program, the teaching strategies supported the objectives and the program objectives were met.

2012 Educational programs

During 2012, the NW provided thirty-eight educational programs (an increase of 34% from 2011) for consumers and professionals along with educational information provided to the facilities for distribution to the patient, dialysis staff and nephrologists. The NW obtained the following continuing education hours: dietitians 9.75 CPEUs, nurses and technicians 39.1 CEUs, physicians 13 CMEs and social workers 6 CEUs. The Network provided quarterly provider education. Patient education was emailed to facilities monthly in 2012.

List of 2012 Educational Programs

Program Title	Date	Number of Attendees	Number of Dialysis Units Represented
Individualized Anemia Management in Patients with CKD on Dialysis	January 15	89	72
NHSN Webinars for NW 4	January 6,13,20,27	NA	NA
Patient Education Lobby Day	February 8	84	1
NW3 PR Learning and Action Network	February 28	10	--
Annual Education Program Puerto Rico	March 4	310	38
ANNA Jersey North: Nephrology, An Environment of Change: The Future of ESRD- "Learn, Act, Improve, Spread"	March 8	--	--
CKD, A Mini Symposium	March 22	70	28
Infection Reduction Initiative	March 22	74	45
Transplant Designee	April 10, 19	465	186 (NJ, NY, PA)
Webinar: Medicare and ESRD	April 24	71	60
Understanding Your Facility's Performance Scores-Second Wave	April 24	44	26
Patient Education Program SBHCS	May 10	12	3
NHSN	May 31	131	150
Dialysis Adequacy	November 29 (2 sessions)	99	74

Program Title	Date	Number of Attendees	Number of Dialysis Units Represented
Fluid Management Part I/Part II	June 8/22	60/55	55/28
Home Designee	June 28	104	71
On-site CROWN training - RCG Lakewood	July 18	6	4
WebEx Understanding the DFR and 2015 QIP Rule	August 7/8	45/67	40/53
Webinar: Importance of Vaccinations in the ESRD Patient (in Spanish)	August 21	41	39
NHSN Enrollment	August 23	NA	NA
NHSN Dialysis Events	August 30	NA	NA
WebEx Rollout of Vaccination Project to Puerto Rico	September 6	23	35
On-site CROWN training – FMC Pomona	September 7	15	10
Bridging the Communication Gap - Public Reporting	September 13	153	110
What You Need to Know about Kidney Transplantation ...and Living donation! Patient Education Program	September 13	54	8
Quality Insights Renal Network 3 Fourth Annual Meeting	October 4	436	102
On-site CROWN training – FMC Newark	October 18	33	16
Chronic Kidney Disease Symposium	October 26	99	24
Dialysis Adequacy Two sessions- 9AM and 1PM	November 29	37/48	39/45
CUSP Rollout WebEx with NJHA.	December 4	31	20
Guidelines for Environmental Cleaning in Dialysis	December 7	67	35

E. Improve the collection, reliability, timeliness, and use of data to measure processes of care and outcomes; to maintain a patient registry; and to support the goals of the ESRD Network Program.

Supportive Activities
The goal of improving standardization of information management within the Network consists of several measures.

In 2012, QIRN3 utilized two different databases to maintain patient data. The Standard Information Management System (SIMS) was used until mid-May when it was closed to allow for data transfer to the Consolidated Renal Operations in a Web-Enabled Network (CROWNWeb) which went live on June 14th, 2012.

SIMS (January 1, 2012-May 18, 2012)
SIMS is an integrated system that provides communication and data-exchange links among the Networks, facilities, and CMS. Each Network had a local database where patient, facility, and facility personnel data was entered and maintained by network staff until May 18th, 2012. Through an automated data transfer application, the SIMS database was replicated to the central repository on a nightly basis.

SIMS was also used for receiving and processing notifications from CMS. Notifications are records in which particular elements, such as patient date of birth, date of death, first name, HIC number, most recent transplant date, most recent transplant failure date, sex, social security number, or surname are found to be different than what is on file with the Social Security Administration. QIRN3 contacted the appropriate facility once each month to verify the suggested data and corrected the information in SIMS.

All data discrepancies were reviewed for validity and accuracy through notifications and discrepancies were resolved within the SIMS database. This process was run on a monthly basis. Data clean-up activities were also run on a monthly basis; utility logs showed resolved queries and any that needed to be addressed.

To accomplish accurate and timely data reporting, all facilities notified QIRN3 of all patient status changes on a monthly basis. Any changes in the dialysis caseload were noted, including:

- Newly-diagnosed consumers who started a regular course of dialysis;
- Changes in modality during the month (e.g., hemodialysis to CAPD);
- Changes in setting during the month (e.g., facility patient who started home dialysis);
- Transfers into or out of the facility during the month;
- Returns to dialysis after renal transplant grafts failed;
- Restarts to dialysis after temporarily regaining kidney function;
- Patient deaths;
- Discontinuation of dialysis treatment;
- Patients who became lost to follow-up; and
- Patients who regained native kidney function to the extent that dialysis was stopped.

Data Reconciliation
Forms employed to maintain QIRN3's patient-specific data system included:

- Monthly Caseload Changes/Census form
- End Stage Renal Disease Medical Evidence Report: Medicare Entitlement and /or Patient Registration (CMS-2728)
- ESRD Death Notification form (CMS-2746)

Forms used to check and reconcile data that were submitted as required, included:

- ESRD Facility Survey (CMS-2744)
- Accretions lists from CMS
- Notifications from CMS
- Federal REMIS web site

QIRN3 staff validated and monitored the accuracy and timeliness of data submissions from all dialysis and transplant programs in New Jersey, Puerto Rico and the Virgin Islands. Facility compliance was monitored for each of the federal medical information system forms listed. Semiannually, the data file was run through customized programming. Two aspects of facility feedback were generated for each of the required forms:

- Compliance rate summary report
- Detail of each form submitted

The compliance rate summary report presented calculations of the number of forms submitted that were within the 30 or 45 day goal, the number of forms with errors and the percent compliance by each facility. The detail report generated patient-specific information on each form.

Forms compliance reports were distributed to facility administrators with the request that they positively recognize those employees who achieved the reporting goal of submitting forms within 30 or 45 days of events. Alternately, if the compliance reports reflected forms that were overdue and outstanding, administrators were expected to follow-up with their employees to correct factors that affected non-compliance.

CROWNWeb (June14, 2012-Present)

CROWNWeb (CW) was released on June 14, 2012 to replace the SIMS database. The system was established in order for all dialysis facilities in the United States and U. S. territories to comply with the Conditions for Coverage. CW allows both the Network and dialysis facilities to see data simultaneously in a live database.

Dialysis facilities use CW to enter and submit patient, facility, facility personnel data, clinical and vascular access data to CMS. This data entry included the submission of CMS 2728, 2746 and 2744 forms previously entered by network staff in SIMS.

Prior to CW, QIRN3 staff validated and monitored the accuracy and timeliness of data submissions from all dialysis and transplant programs in New Jersey, Puerto Rico and the Virgin Islands. Facility compliance was monitored for each of the federal medical information system forms listed through various reports available in SIMS. At this point, however CW does not have a mechanism in place to calculate CMS forms compliance rates. To compensate, QIRN3 ran weekly missing forms report and contacted facilities directly to address these missing forms.

The monthly caseload change report previously submitted by network staff in SIMS is now being entered directly by facility staff or batch submission. CW provides a Patient Attributes and Related Treatment (PART) section which allows facilities to verify their current caseload on a monthly basis.

CW was also used for receiving and processing notifications and accretions from CMS. Both notifications and accretions are loaded and assigned to facilities and QIRN3 on a daily basis. The facility and network staff verify the data through an Action List and either accept or reject the suggested value from the CMS enrollment database. All items on the Action List should be addressed within 30 days of notification.

Transplant Facility Data Submission

At this time our network's six transplant facilities do not have access to CW and continue to submit data manually to QIRN3. The data is then entered in CW by network staff. This data includes all transplant activity and the submission of CMS 2728, 2746 and 2744 forms.

Each month the United Network for Organ Sharing (UNOS) provided a downloadable Network-specific transplant list which was also used to identify/verify transplants performed.

Gaining Access to CROWNWeb

In order to gain access to CW, networks and facilities, alike completed applications through the QualityNet Identity Management System (QIMS). QIMS provides an Identity and access management system integrated with a two factor solution. It ensures secure, distributed, and consistent account management, and authentication services for applications requiring multifactor authentication. These services are provided in a consistent, repeatable, and highly secure method. CW is one of many applications that are utilizing QIMS.

QIMS provides tiered levels of account access and management to CW. Each facility should have a Security Official (SO), End User Manager (EUM) and an End User (EU). The SO must approve the application for the EUM, ensures that the EU has completed CMS security training and activates the user's account in QIMS. The EUM receives reviews and approves the EU's application and sends it to the SO for activation. The EU logs into QIMS to apply for CW access and submits requests to the EUM for approval.

Each user must complete two applications, Part A form which is the general QIMS account information and the Part B form which is the CW portion that defines a user's role and scope. The user role defines what tasks the user is able to perform; while the scope determines at which facilities the user can perform those tasks. Roles include Facility Administrator, Editor and Viewer. The Facility Administrator may read information and assign role and scope for users within their scope. The Facility Editor may read, add and edit information; and the Facility Viewer may read information only and cannot make any changes in the system. Applicants must also complete security training annually and enclose a certificate of completion with their initial applications.

CMS Notifications

CMS notifications are requests for patient database validity information. Each day notifications were sent to those facilities where discrepancies were noted by CMS. Facilities then reviewed the element in question and either accepted or rejected the enrollment database value directly in the CW system. The verification of this data ensured accurate data in the national database and REMIS.

End Stage Renal Disease Medical Evidence Report: Medicare Entitlement and/or Patient Registration (CMS-2728)

The End Stage Renal Disease Medical Evidence Report: Medicare Entitlement and /or Patient Registration (CMS-2728) is the initial reporting form for all persons with end-stage renal failure who began a regular course of dialysis or had a renal transplant as a first form of therapy. The form was completed and submitted to QIRN3 by facilities and veterans' administration hospitals according to federal regulations. Submission is expected within 45 days of the start of renal replacement therapy whether or not the patient applied at that time for financial coverage under the federal Medicare program.

End Stage Renal Disease Death Notification form (CMS-2746)

The End Stage Renal Disease Death Notification Form (CMS-2746) is a one-time form completed when a dialysis patient dies. The purpose of the form is to notify Medicare of the date and cause of a patient's death. The 2746 form is to be completed by the transplant or dialysis center that was last responsible for the care of the patient on an ongoing basis, regardless of the place of death**.**

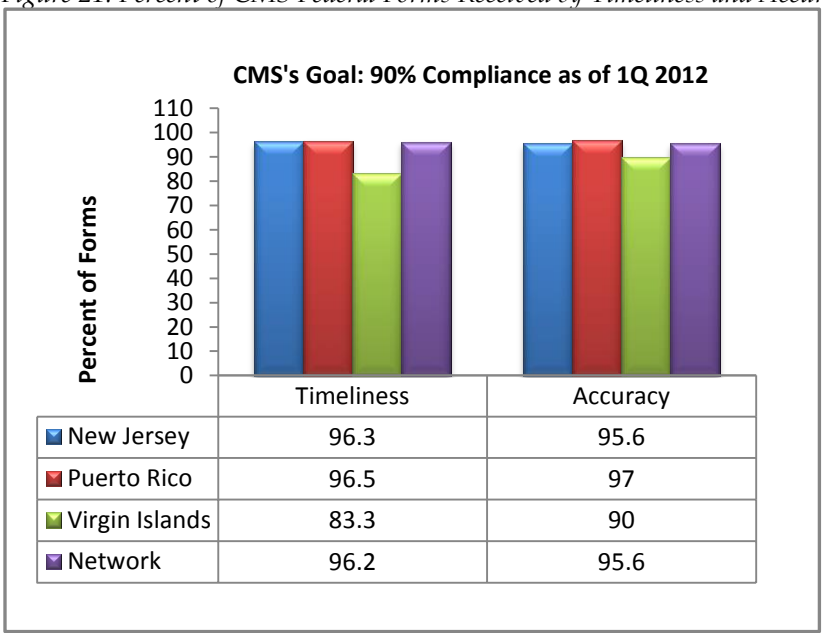
CMS goal for Federal Forms Compliance

CMS sets a goal for Networks that require them to ensure that facilities submit 90% of forms accurately and on time. As there is not a mechanism to calculate this rate in CW, the network can only report that it exceeded the goal for both timeliness and accuracy for the first quarter of 2012.

QIRN3 staff entered data from the forms into computer software supported by the federal government from January to Mid-May of 2012. If data required on the form were missing or incompatible with CMS software, the form was rejected by the software and returned to the facility for correction.

For the first quarter of 2012, QIRN3's dialysis facilities submitted 96.2% of its federal forms on time and 95.6% of the forms submitted were accurate. New Jersey facilities submitted 96.3% of its forms on time and 97.0% were completed accurately. Facilities in Puerto Rico submitted 96.5% of its forms on time and 92.8% were completed accurately. While the Virgin Islands submitted 83.3% of its forms on time with an accuracy rate of 90.0%.

Figure 21. Percent of CMS Federal Forms Received by Timeliness and Accuracy



	Timeliness	Accuracy
New Jersey	96.3	95.6
Puerto Rico	96.5	97
Virgin Islands	83.3	90
Network	96.2	95.6

Source: SIMS Database

In addition to receiving, processing, and transmitting data reported on the federal medical information system forms, QIRN3 maintained a patient tracking system (SIMS) that tracked end-stage renal disease consumers through changes in treatment modality and setting. Changes in provider were also tracked. Once CW was released, QIRN3 supported facility staff in their application and understanding of the new system. These activities were necessary to support federal quality projects and special studies. Monitoring patient events was also necessary for the reconciliation of the annual federal ESRD Facility Survey, preparation of facility profiles for goal achievement in home dialysis use and referral, and local quality of care improvement efforts.

Data accuracy and forms timeliness was reviewed through first quarter 2012 and documented. Both federal forms were profiled for compliance rate analysis for first quarter 2012.

UNOS

Renal transplant registrations and follow-ups were resolved through updates and verifications within the SIMS, CW and UNOS databases. Data were received monthly from UNOS and entered into the SIMS and subsequently the CW databases. Discrepancies were reviewed with transplant facilities and reconciled in CW.

VISION

The use of the VISION database for data submission by a select group of dialysis facilities in this network was discontinued with the release of CW in June of 2012.

REMIS

The federal REMIS system is an important component of the CROWN system and is based on federal billing records. Data entered into SIMS and CW by QIRN3 staff can be viewed there, as

can data sent from sources such as CMS, the Social Security Administration, and UNOS. The data can be used to resolve discrepancies and complete patient event histories.

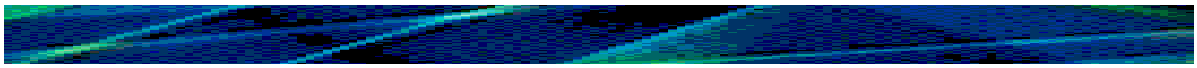
Network staff used the Alerts tool in REMIS to identify incorrect patient identifiers and maintain a more accurate data set. Out-of-area transfers were verified in this database.

Effectiveness
All tracking databases must have current, accurate information and facility cooperation is essential to this effort.

QIRN3 continued to support the CW database by training facility staff in newly certified facilities and in existing facilities when assigned staff changed.

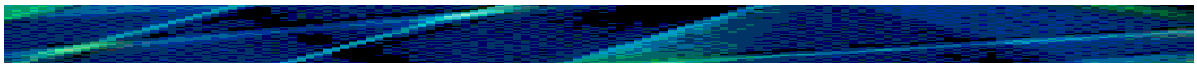
Consumer Impact
An accurate database is essential for the analysis of clinical indicators. Performance analysis activities utilize current, reliable data to monitor clinical patient outcomes. QIRN3's efforts to improve data accuracy enhanced data reliability and assured appropriate facility review with improvement plan oversight.

Accurate and timely reporting of patient data is essential for determining the starting date of Medicare coverage. QIRN3 continued to maintain a database high in accuracy and timeliness.



IV. Sanction Recommendations

No recommendations for sanctions were made in 2012.



V. Recommendations for Additional Facilities

In all three geographic areas, access to dialysis therapies is within reasonable travel distances from ESRD consumers' homes. No additional New Jersey, Puerto Rico, or Virgin Islands dialysis facilities were recommended.