



# **Trans-Atlantic Renal Council**

## **2008 Annual Report**

ESRD Network 3  
Contract Number: 500-03-NW03

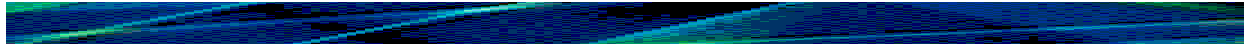
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June 30, 2009



## I. Preface

I am pleased to submit this annual report of performance and achievement on behalf of the Board of Trustees, Medical Review Board and all ambulatory renal care facilities in New Jersey, Puerto Rico and the Virgin Islands.

TARC has achieved significant improvement in the use of fistulas in appropriate patients since starting the initiative in 2004; the initial 34.9% increased to 51.4% at year-end 2008. Inappropriate catheter use declined from 34.7% to 28.7% during the same time period. Admittedly, catheter reduction requires continued attention and providers are investigating alternative approaches in order to improve performance.

The use of subclavian and non-tunneled catheters was found to be a particular problem in an area; the rates in January 2007 were 23% and 10.6%, respectively. The rates decreased further to 8% and 5% by December 2008 with further improvement expected.

Although the number of patient complaints and involuntary discharges is increasing across the United States, TARC works with each patient and facility to encourage a satisfactory resolution. All but one of twenty-seven involuntarily discharged patients in 2008 could not be accommodated in an established ambulatory dialysis facility.

TARC addressed other clinical areas and met with success: clinical performance indicators exceeded national averages in anemia management, incident fistula patients, stenosis monitoring and target phosphorus levels.

We look forward to the continuation of this partnership with the Centers for Medicare & Medicaid Services, facility staff, consumers, departments of health and other interested agencies as we begin another phase of health care quality improvement projects.

***Toros Kapoian, MD, FACP***

Toros Kapoian, MD, FACP  
President, Board of Trustees

June 30, 2009



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## II. Introduction

### A. Description of Network Area

#### New Jersey

#### Geography and General Population Characteristics

At first glance, the composition of Network 3 may seem unusual since the areas are geographically distant; however, on closer examination the residents are remarkably similar in many ways. Climate is the singular attribute which differs as can easily be understood and clinically, the rate of diabetes is higher in the islands. Each area is described separately.

New Jersey contains 8,215 square miles with 21 counties and 567 municipalities. Its highest elevation is 1,803 feet at High Point and its lowest is sea level at the Atlantic Ocean with an average elevation of 250 feet. New Jersey is geographically one of the smallest states in the nation (it ranks 46), in 2007 it was estimated by the Census Bureau to be the eleventh most populous, with approximately 8.7 million residents. There are 1,171 inhabitants per square mile of land area - the most densely populated state in the nation<sup>1</sup> followed closely by Rhode Island. The population is expected to increase 24% by 2030. Internal outmigration in New Jersey from 2000-2007 was exceeded only by New York, California and Illinois.

California and New Jersey are the only two states with a population that is 94.4% urban. The District of Columbia ranks higher at 100% urban.

Not all age groups are equally constituted. The under-5 age group constitutes 6.7% of the resident population; the 5-17 age group accounts for 18% of the population; the 18-24 group for 8.5%, the 25-44 age group for 28.9%, the 45-54 for 14.7%, the 55 to 64 group for 10.1% and the 65+ group for 13% of the population. It is important to note that from 1990 to 1998, the 85 and older age group increased by 38%. This growth in the aged population among the residents of New Jersey contributes to the increase in the mean age of consumers presenting for renal therapy due to end-stage disease.



The population is reported to be 76% white, 15% black, 8% Asian and 1% other. Most of the population growth in New Jersey during the last decade occurred in minority populations; Hispanics sustained the largest increase. Hispanics now constitute approximately 14.5% of the population within New Jersey, and

<sup>1</sup> All demographic data are taken from the *Statistical Abstract of the United States:2009-128 ed.*, US Census Bureau, Washington, DC, 2008, and earlier editions unless otherwise noted.

Hispanics of Puerto Rican decent comprise more than 33% of all Hispanic residents. The largest increase of New Jersey's Hispanic residents occurred in Hudson and Passaic counties. Chronic kidney disease has a higher incidence among the black and Hispanic populations.

New Jersey is surpassed by only 6 other states in the proportion of resident Hispanic or Latino residents; California (34.3%), Texas (33.6%), Arizona (27.7%), Florida (18.6%), Illinois (13.6%) and New York (16.3%) surpass New Jersey's 13.3% resident Hispanics and Latinos. New Jersey's foreign-born population accounted for 17.5% of the population, surpassed only by California and New York.

For the year 2003, New Jersey remained fifth in the number of immigrants admitted from other countries and was surpassed only by the states of California, Florida, New York and Texas. The US Census Bureau reported the admission to New Jersey of 40,699 immigrants from other countries, with 7,442 from India, 3,956 from the Dominican Republic, 2,639 from the Philippines, 1,922 from Columbia, 1,686 from China, 631 from El Salvador and 431 from Vietnam. Foreign-born residents account for 17.5% of the state's population, exceeded only by California (26.2%) and New York (20.4%).

The state ranked eighth in the number of unauthorized immigrants, surpassed by California, Texas, New York, Illinois, Florida, Arizona, and Georgia. Mexico was identified as the country of origin for 69% of these persons.

Health insurance coverage in 2006 did not extend to 13.3% of the New Jersey population; the national average was 11.7%, exceeded by 10 other states. Children not covered in New Jersey in 2005 constituted 10.5%, and 9.3% in 2000; the national average was 10.9% in 2005 and 11.6% in 2000.

The New Jersey population estimated to be below the poverty level in 2006 was 8.7%, higher than the 2000 rate of 7.9%; the 2007 national rate was 13.3% compared to the 2000 rate of 12.2%. Only 3 states had rates lower than New Jersey in 2006. In 2007 New Jersey again ranked second, after Connecticut, in per capita personal income, which is the same as was seen in 2000.

## **INCIDENCE OF RENAL DISEASE IN NEW JERSEY**

According to the 2008 ESRD Facility Survey, 3,491 people initiated treatment compared to the 3,527 in 2006, and 3,251 in 2004. Older people, in particular those over 65 years of age, continued to represent the largest and fastest growing age group of ESRD beneficiaries. Of the total new starts in 2008, 56% were 65 years or older, and 45% were 70 years or older. Twenty-two percent were ≥80 years old compared to 18% in 2006.

USRDS 2006 data show the adjusted incidence rate was 385.1/m, 368.7/m in 2005 and 356.1 in 2000.<sup>2</sup>

Males accounted for 58% of the incident caseload which is higher than previously seen, 64% white and 31% African American.

Among incident cases, the most frequently reported primary diagnoses were diabetes (43%) and hypertension (29%). Collectively, these two diagnoses represented the largest proportion of new cases in 2008.

## **RENAL THERAPY IN NEW JERSEY**

The New Jersey Department of Health regulated the approval of all new ESRD providers and expansion of services through the certificate-of-need process until January 1992. Since that time, chronic

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<sup>2</sup> US RenalData System, *USRDS 2008 Annual Data Report Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States*, NIH, NIDDK, Bethesda, MD. 2007, Vol II, Table A9, p.23.



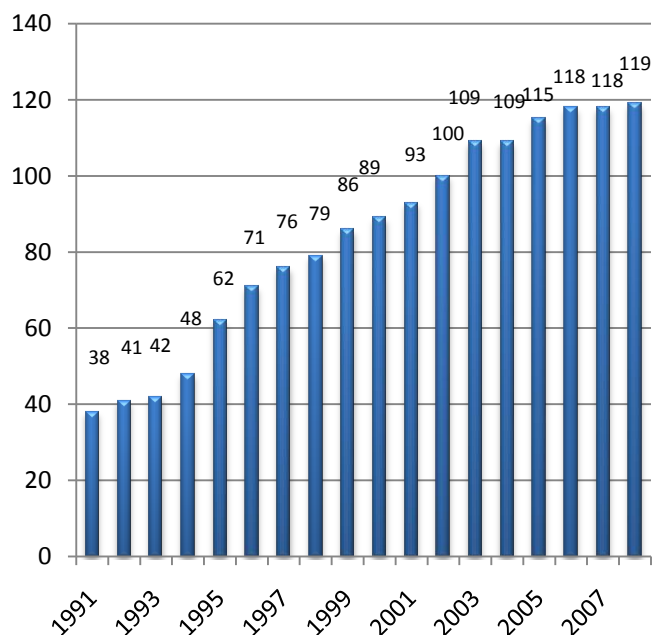
ambulatory dialysis was no longer subject to certificate-of-need requirements. The number of facilities increased from 38 in 1991 to 118 (not including a non-Medicare certified ESRD veterans' hospital) in 2008.

In 2008, the total approved station count rose to 2,142 in 123 Medicare-certified facilities. Most facilities are no longer hospital-based since 87 freestanding clinics and 11 hospital satellite facilities provide service. There were 24 hospital-based facilities and one veteran's administration hospital, which is not a participant in the Medicare program.

Almost all facilities were approved to provide staff-assisted hemodialysis except for 2 peritoneal dialysis-only units. Of the facilities offering home dialysis 37% had CAPD/CCPD patients; 13% had hemodialysis home patients. These services reflect the choices among patient and physician preferences for therapy and were available throughout the state.

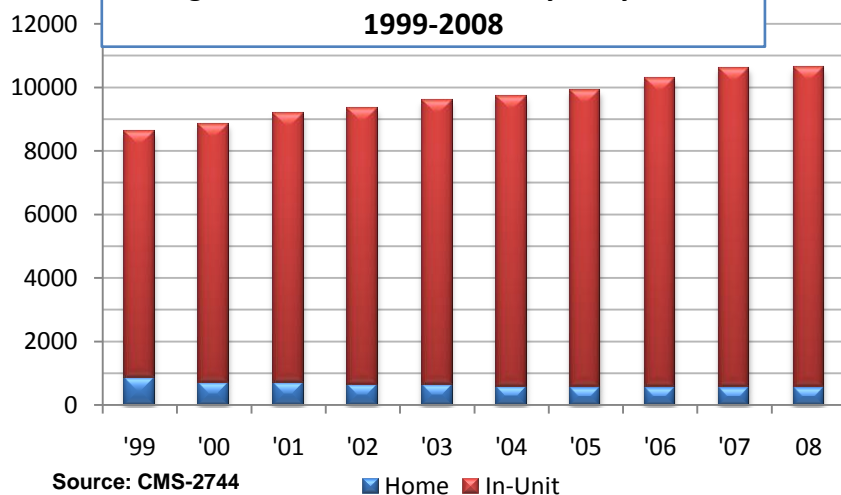
Staff-assisted hemodialysis, favored by 95% of ESRD consumers (83% in 1996), remained the dominant therapy in the state. Continuous cycling peritoneal dialysis (CCPD) became the dominant home therapy (n=380), with continuous ambulatory peritoneal dialysis (CAPD) the second most prevalent (n=125). Home hemodialysis accounted for only 42 cases statewide in 2008.

**Number of New Jersey ESRD Facilities  
Network 3**



Source: CMS certification letters

**Setting Distribution of New Jersey Dialysis Cases,  
1999-2008**



Source: CMS-2744

■ Home ■ In-Unit

## **PREVALENCE**

The USRDS published adjusted annual point prevalence rates/million population for 1996-2006 by state. New Jersey results were 1167.8, 1219.9, 1277.7, 1339.9, 1372.9, 1404.1, 1430.1, 1459.8, 1487.4, 1530.8 and 1,577.5, respectively.

The 2007 New Jersey prevalent caseload increased 3% over the prior year. Of the approximately 10,900 prevalent consumers receiving dialysis in New Jersey, 57% were male and 43% female. Forty-two percent of the population on dialysis was black, 52% white, with other racial groups constituting the remainder.

Thirty-eight percent of the consumers receiving chronic dialysis in New Jersey during 2008 were seventy years or older; 61% were aged sixty years or older. The aged population continues to be the fastest growing segment both receiving long-term chronic care and initiating treatment.

Diabetes was the most frequently reported primary disease of all prevalent consumers on dialysis at 41%. Hypertension followed at 29% of the caseload and "other" ranked third at 13%. The majority of consumers (71%) in treatment were diagnosed with either diabetic nephropathy or hypertensive disease—the two leading national risk factors for ESRD.

The mean age of the prevalent patient population in 1980 was 49.6, in 1990 it was 53.4, in 2000 56.8, in 2004 it was 57.7 and in 2006 58.1 showing a steady progression toward an older population.

## **MORTALITY DATA**

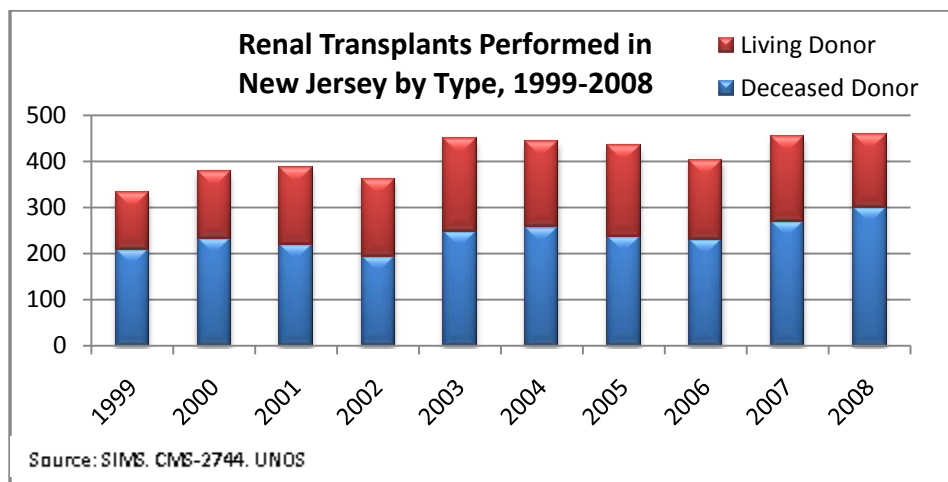
Death notification reports for New Jersey ESRD consumers were analyzed by sex, race, and cause of death. The primary cause of death reported in 2008 continued to be cardiac (48%), which again reflected national data. Infection was reported as primary cause in 16% of the 2539 death records received. Of all deaths reported in 2008, 66% were white, 30% black; 57% were male, 43% female. Primary diagnoses among deaths reported were diabetes (45%), hypertension (31%), glomerulonephritis (5%), polycystic disease (1%), and other/unknown.

## **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 2008, 458 transplants were performed in New Jersey at federally certified ESRD renal transplant centers, a 1.3% increase from 2007 total of 452 transplants. Of the 458 transplant procedures performed within New Jersey, 65% (300) had cadaveric donors and 158 had living donors.

The number of consumers on a waiting list in New Jersey as of December 2008 decreased slightly to 1,084. 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.



## Puerto Rico and the Virgin Islands

### Geography and General Population Characteristics

#### Puerto Rico

Similar to New Jersey, Puerto Rico is densely populated (1,124/sq. mi.) with land area covering nearly 3,425 square miles and an estimated 2008 population of 3.958 million<sup>2</sup>. There were 1,027.9 inhabitants per square mile according to the 2000 census. Between 1990 and 2000, the population increased 8%.



The area has commonwealth status to the United States and is an unincorporated territory. Status relationship to the United States is under discussion with the US Congress and among island residents. The main island of Puerto Rico, Culebra, Mona and Vieques are all included in the area territory. All residents born in the area are United States citizens.

Tectonic plate locations near the island make it susceptible to earthquakes, landslides and tsunamis, with the last major earthquake estimated at 7.5 on the Richter scale in 1918. Droughts are one of the naturally occurring hazards to the local population. Sediment buildup (60% storage reduction over the last 50 years) in reservoirs reduced the holding capacity of several major water supplies. Reclamation efforts are underway and should reduce the periodic threat to potable water supplies. The U.S. Geological Survey works with 15 local agencies to operate a real-time hazard alert network concerned with rainfall, stream flow, lake levels and beach erosion from catastrophic events<sup>3</sup>.

<sup>2</sup> Source: *Statistical Abstract of the United States: 2009*, US Census Bureau, US Dept of Commerce, 2008

<sup>3</sup> Source: GSA Center, US Geological Center, *Island hydrology: Puerto Rico and the US Virgin Islands*, at <http://pr.water.usgs.gov/public/webb/webb010>

The island is rich in culture from the various settlers throughout its history. The primary influence is Spanish although the Taino culture predated Spanish colonization. In later years, other European immigrations from Corsica, France, Scotland, Ireland, Africa, Germany, China and Portugal to the island were recorded.

Tourism and manufacturing, particularly pharmaceuticals, are prime economic engines on the island. One in every four Hispanic families lives at the federal poverty level, with average earnings well below the U.S. national average. Forty percent of all households rely on some form of public assistance. The average monthly benefit paid to retired workers is \$527. The average annual employee compensation reported by the most recent Bureau of the Census publication (2000) was \$20,064; the average family income was \$33,559.

### The U.S. Virgin Islands

The territory of the Virgin Islands consists of three islands - St. Thomas, St. Croix and St. John - and about 50 islets, most of which are uninhabited. These islands are located 60 miles southeast of Puerto Rico, between the Caribbean Sea and the Atlantic Ocean, in the Lesser Antilles chain of the West Indies. It is an unincorporated territory of the United States administered by the Office of Insular Affairs, U.S. Department of the Interior. The governor and lieutenant governor are elected for four-year terms.

The land area covers 134 square miles with an overall population estimated to be 110,000. There were 810 residents/sq. mi. in 2000. Population density fluctuates among the individual islands. St. Thomas has the highest density with 1,579 persons per sq. mi.; St. Croix has 583/sq. mi. and St. John only 118/sq. mi.



Storms and hurricanes have done significant damage in the past, closing the port to cruise ships for several years. These remain a threat during storm season.

**Population of the US Virgin Islands, 1990 and 2000**

Island	1990	2000	2008	% change
St. Croix	50,139	53,234		6.2
St. Thomas	48,166	51,181		6.3
St. John	3,504	4,197		19.8
All	101,809	108,612	110,000	8.0

Source: US Census Bureau, *Statistical Abstract 2004-2008*.

Residents are comprised of people from the West Indies (45% native to Virgin Islands, 29% born elsewhere in West Indies), Puerto Rico (5%), U.S. mainland (13%), and other (8%)<sup>4</sup>. Racial composition

<sup>4</sup> Source: [www.infoplease.com/ipa/A0113951](http://www.infoplease.com/ipa/A0113951); [www.cia.gov/cia/publications/factbook/print/vq](http://www.cia.gov/cia/publications/factbook/print/vq)

in the Virgin Islands is estimated to be 80% black, 15% white and 5% other. Spanish and Creole are spoken in addition to English.

Tourism is the major economic stimulus in the area as well as some manufacturing sectors. One of the world's largest petroleum refineries is located here. The unemployment rate is higher than the mainland at 10.6%<sup>3</sup>.

#### **US Virgin Islands Population by Age Group, 2000 and 2006**

<b>Age Group</b>	<b>2000</b>	<b>2006</b>
0-24	42,855	37,792
25-54	44,883	43,286
55-64	11,652	14,630
65-74	5,931	8,096
75-79	1,626	2,217
80+	1,690	2,427
All	108,637	108,448

Source: US Bureau of the Census, International Database.

#### **Renal Disease: Puerto Rico and the U.S. Virgin Islands**

The number of newly diagnosed ESRD cases, was 1,337 in Puerto Rico and 55 in the Virgin Islands. Sixty-eight percent of the newly diagnosed in Puerto Rico and 60% in the Virgin Islands were reported to have a primary diagnosis of diabetic nephropathy. This continued to parallel the national trend of the growing number of diabetics starting dialytic therapy and represents a marked increase from 1990 when diabetes as the primary cause in new cases was only 45%. Hypertension was the second highest reported diagnosis at 13% with glomerulonephritis the next highest at 7% with comparable rates in the Virgin Islands of 26% and 2% respectively.

These rates vary when analyzing the data received on all prevalent consumers alive at year-end 2008 on the islands. At year-end in Puerto Rico, 4,246 consumers received treatment, compared to the prior year 4,031, a 5% increase from 2007. Of these consumers, 41% reported diabetes as primary cause of renal failure, 10% glomerulonephritis, and 29% hypertensive disease. Comparable rates for the Virgin Islands were 50%, 9% and 29%. The majority of consumers in Puerto Rico were reported as white (67%), racially mixed (26%) and male (61%). In the Virgin Islands, 89% were African American and 62% male.

Age grouping was widely divergent for both new cases and the prevalent patient population on the islands. In Puerto Rico, the incident and prevalent populations in the 50-69 age group were largest, 49% and 53% respectively. Twenty-eight percent of prevalent cases are between the ages of 30 and 54. Thirty-three percent of the incident cases are aged 70 or more.

In the Virgin Islands, the incident and prevalent populations in the 60-74 age group were largest, with 60% and 49% respectively. Thirty-three percent of prevalent cases were between the ages of 30 and 54. Twenty-six percent of the incident cases were aged 70 or more.

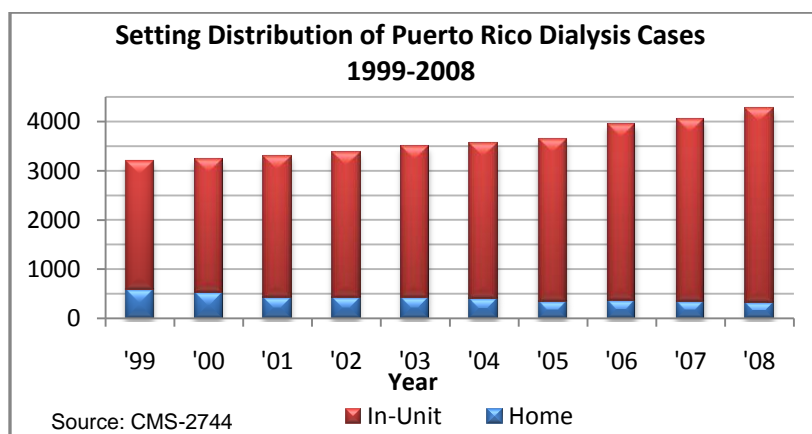
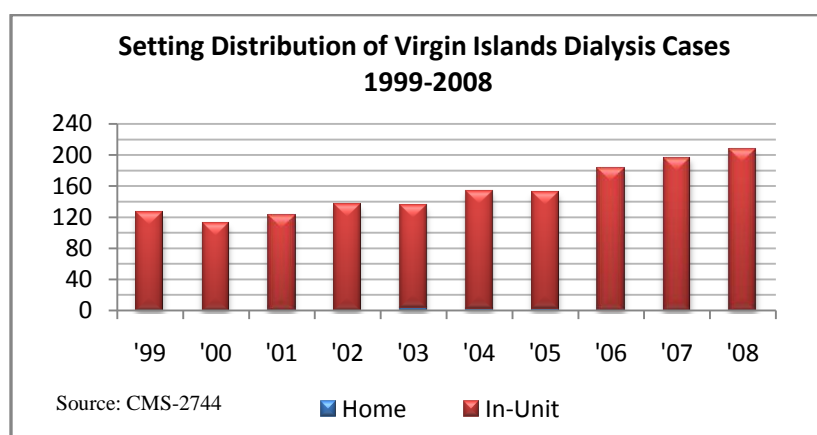
The primary cause of death for ESRD consumers treated in Puerto Rico at year-end was cardiac (34%), followed by infection (29%). The primary cause of death for ESRD consumers treated in the Virgin Islands at year-end was cardiac (32%); infection ranked second (29%).

#### **Treatment Modalities**

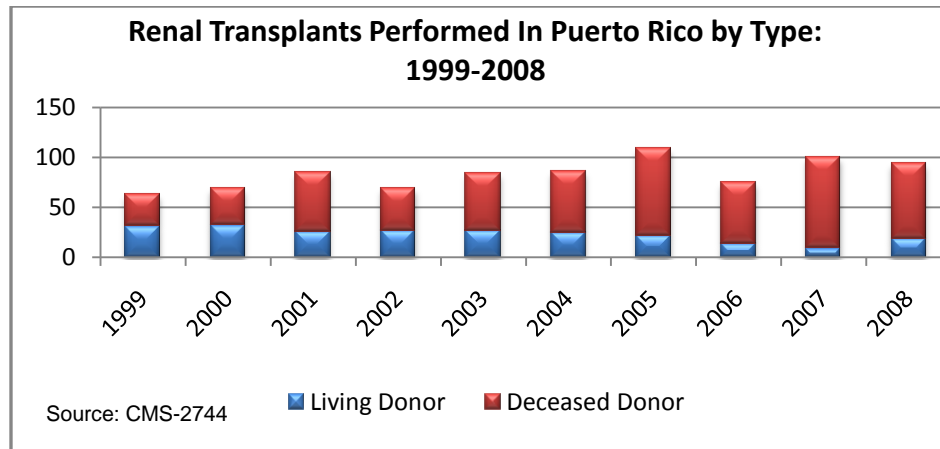
Forty-one facilities were approved to provide dialysis services on the island of Puerto Rico, one transplant center, and a non-Medicare veterans' hospital; 3 dialysis facilities were approved in the Virgin Islands.

Thirty-two facilities located on Puerto Rico were freestanding clinics, 6 were hospital-based units, one a pediatric hospital and a non-Medicare approved veterans administration hospital. The station count increased in 2008 to 850 from 750 in (inclusive of Puerto Rico and the Virgin Islands). The three facilities on the Virgin Islands had a total of 30 stations and 207 cases at year-end.

Treatment choice by 3,950 (93%) consumers in Puerto Rico and all consumers in St. Thomas and St. Croix continued to favor staff-assisted hemodialysis. Self-care training in CAPD, CCPD and home hemodialysis was provided in Puerto Rico. Eighty percent of the home population in Puerto Rico was on home CCPD. In 2008, 256 consumers were on CCPD and 61 consumers were on CAPD; 2 consumers used home hemodialysis. The combined total of consumers on various forms of home dialysis in Puerto Rico was 319 in 2008, 363 in 2006, 400 in 2004, 521 in 2000, and 679 in 1998. In St. Croix, no consumers were on CAPD or CCPD.



In 2008, 94 transplants were performed in Puerto Rico's one Medicare-approved transplant center which was a decrease of 6% from the 100 performed in 2007. Of these procedures, 75 were from cadaveric donors and 19 from living donors. There were 423 consumers on an active waiting list which is a slight decline from the previous year's 453.



Formerly, the organ procurement agency was located at the transplant hospital and was part of that organization. In 1996, a separate agency, Life Link of Puerto Rico, was established, which is affiliated with Life Link of Florida.

## B. Network Structure

### 1) Staffing

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

### 2) Names and Titles of Staff

Cheryl Brown <i>Data Clerk</i>	Beverly Hoek <i>QI Administrator</i>	Tricia Phulchand <i>Office Manager</i>
June Chronic Huhn <i>Patient Services Coordinator</i>	Chris Brown <i>Data Manager</i>	Patricia Llewelyn <i>QI Coordinator Community Outreach Coordinator</i>
Patricia Dorsa <i>Bookkeeper</i>	Joan Solanchick <i>Executive Director</i>	Amy Yeager <i>Clerk</i>

### 3) Key Responsibilities

Joan Solanchick, MSW, RN, Executive Director

Administered the financial and operational aspects of the contract, provided advice to the Board of Trustees and Network Council on goals, objectives, work plans, policies and procedures; maintained external relations through ongoing communication with other agencies, state programs and the general public; processes all patient grievances following established procedures, and supervised daily operations.

Beverly Hoek, RN, CNN, Quality Improvement Administrator

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.

Patricia Llewelyn, RN, CNN, Quality Improvement Coordinator (part-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 and assisted with the clinical performance measures project.

Community Outreach Coordinator (part-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.

June Chronic Huhn, MPA, RN, CNN, Patient Services Coordinator

Assumed a proactive role in the facilitation and resolution of patient and/or facility situations. Maintained a computerized log of contacts in SIMS. Coordinated Patient Advisory Committee and appropriately focused their activities. Wrote patient newsletters and developed or identified new educational material for dialysis unit personnel and patients. Through educational programs promoted an increased awareness of treatment options and rehabilitation.



**Chris Brown, 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 of patient data and security, maintenance of computer systems and updated the patient and facility-specific database; served as a resource to providers and Network staff.

**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; and, maintained phone contact with facility staff to answer questions regarding completion of forms and to obtain missing data.

**Tricia Phulchand, BS, Office Manager**

Provided administrative support to all staff; supervised data clerk and part-time clerk. Monitored all project submissions as well as assisted in the implementation of facility transmission of VISION data and monitored complete and timely data submission. Assisted in meeting arrangements, supervised all bulk mailings and supported QI activities.

**Amy Yeager, Clerk**

Performed data entry of medical forms, provided copying and mailing support, assisted the office manager with QI activities.

These individuals provided the clinical and administrative expertise to assure reliability of statistical data and oversight of quality improvement activities.

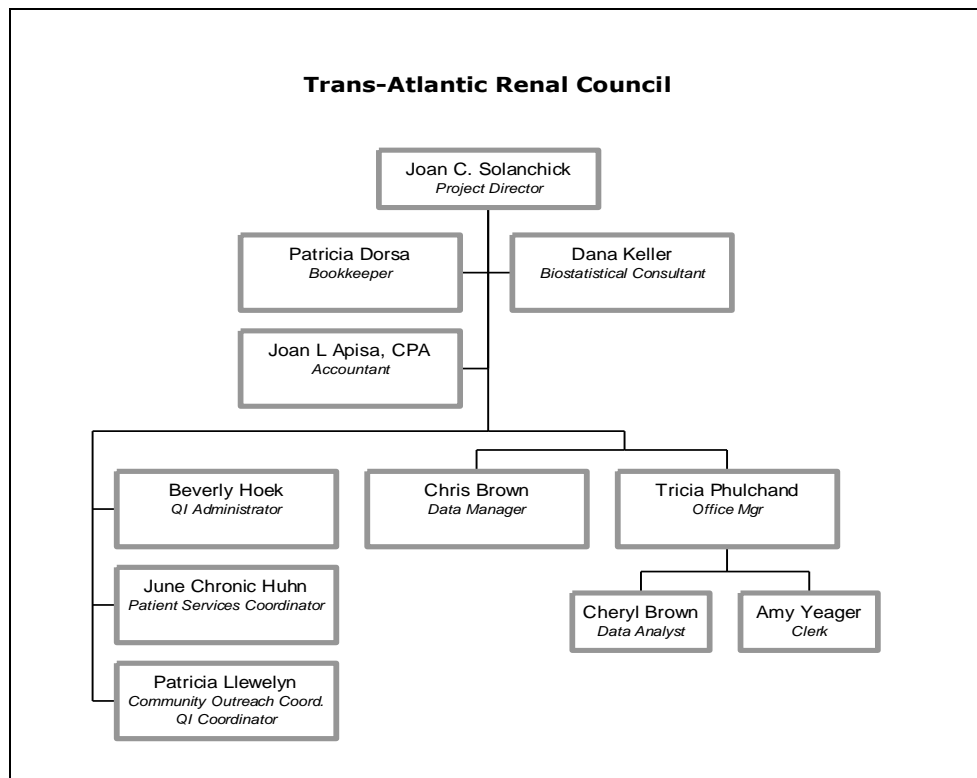
## **OPERATIONS**

There are two major functions within the operation of the Network: quality improvement and data management. It could be maintained that quality improvement is the sole function of the Network and data analysis serves only to focus and measure the quality improvement function.

Quality improvement personnel were responsible for staffing the Medical Review Board and all related activities, the federal clinical performance measures project, local quality improvement activities and educational programming. Staff prepared draft material for review by the Medical Review Board, monitored developments in the field, reviewed reports submitted by each facility and analyzed comparative results. Facility site visits and regional training sessions were conducted when appropriate.

Data management personnel were responsible for all data input, report production, generation of compact disks and transmission of data to CMS. They subjected data to tests of statistical significance and interpreted results for clinical personnel as well as assisted in designing studies and producing reports.

Clerical personnel prepared documents, correspondence and general mailings as well as maintained files in a manner consistent with usual office practice.



Network staff conducted ongoing data collection and processing, review of compliance with federal requirements as well as Network goals and objectives, and distribution of pertinent information to all facilities within the defined geographic region.

The Council of member facilities and Patient Advisory Committee provided the direction for monitoring performance outcomes and measuring the quality and appropriateness of care. The Medical Review Board and the Board of Trustees provided advice and expertise to achieve improvements in patient care. In addition, a resource pool of knowledgeable consumers and other highly skilled clinical nephrology professionals (physicians, registered nurses, social workers and dietitians) was developed to act in a consulting role for periodic review of educational materials, special studies, core indicators and speakers at educational meetings.

This resource pool has been valuable in assisting staff to test new data requirements and changes in quality improvement activities, and to analyze the impact of advancing technology or areas of interest. All board and committee members serve voluntarily with no compensation.

#### 4) Committees

The basic committee structure included the Board of Trustees, the Medical Review Board and the Patient Advisory Committee. Other committees and subcommittees are established when the need arises.

## 5) Functional Description

### Network Council

The Council provided broad direction and guidance in the development of goals for self-care, transplant referrals and criteria selection for monitoring performance of 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.

The Council was composed of thirty-three (33) regular members: twenty-four (24) from New Jersey, six (6) from Puerto Rico/Virgin Islands, and three (3) consumers. The formal Council representatives reflect the geographic area encompassed by the Network as well as the various disciplines and types of facilities contained within the Network. All Council members were selected from volunteers and approved by the Board of Trustees. Liaison members from governmental and voluntary agencies affiliated with the care of ESRD consumers were invited. Council meetings are open and a significant number of the renal community attends the annual meeting. The following chart illustrates the Council's composition.

North NJ	South NJ	Puerto Rico	Virgin Islands
2 consumer	1 consumer		
10 physicians	4 physicians	2 physicians	1 physician
3 registered nurses		2 registered nurses	
1 social worker	1 social worker		
2 administrator	1 administrator	1 administrator	
1 dietitian	1 dietitian		

Council formal representation by type of facility follows:

	New Jersey	Puerto Rico	Virgin Islands
Hospital-based	8	1	1
Non-profit satellite	4		
Corporate provider	12	4	
Patients	3		

Members included:

Alexandre Ackad, MD  
Nephrologist  
Hackensack University MC  
Hackensack, New Jersey

Rosemary Acuna, RN  
Kidney Transplant Patient  
Livingston, New Jersey

Kevin Barber, MD  
Nephrologist  
Bridgeton South Jersey Hospital  
Bridgeton, New Jersey

David Blecker, MD  
Nephrologist  
DCA Vineland  
Vineland, New Jersey

Raphael Burgos Calderon, MD  
Nephrologist

Toros Kapoian, MD  
Nephrologist  
Robert Wood Johnson U MC  
New Brunswick, New Jersey

Phyllis Leggett, MSW  
Social Worker  
DCA Manahawkin  
Manahawkin, New Jersey

Mary Lorenzo, MSW  
Kidney Transplant Patient  
Matawan, New Jersey

Neil Lyman, MD  
Nephrologist  
ST. Barnabas MC  
Livingston, New Jersey

Phyllis Micchelli, LCSW  
Social Worker

Atlantis Mayaguez  
Mayaguez, Puerto Rico

John Capelli, MD  
Nephrologist  
Our Lady of Lourdes Hospital  
Camden, New Jersey

William Chenitz, MD  
Nephrologist  
FMC Irvington  
Irvington, New Jersey

Kim Kellar, RN  
Administrator  
Kennedy Hosp Dialysis Ctr  
Voorhees, New Jersey

Debra DiNuzzo, RD  
Renal Dietitian  
DVA Atlantic AAKC  
Eatontown, New Jersey

Luis Emanuelli, MHA  
Chief Executive Officer  
Fresenius Medical Care  
Puerto Rico

Paul Fine, MD  
Nephrologist  
Morristown Memorial Hospital  
Morristown, New Jersey

Noemi Figueroa, BSN  
Nurse manager  
FMC Carolina  
Carolina, Puerto Rico

Melvin Goldblat, MD  
Nephrologist  
Newark Beth Israel MC  
Newark, New Jersey

Stuart Homer, MD  
Nephrologist  
DVA Perth Amboy  
Perth Amboy, New Jersey

Wishburne Hunte, MD  
Nephrologist  
Roy Schneider Hospital  
St. Thomas, USVI

Kevin James, MD  
Vascular Surgeon  
Morristown Memorial Hospital  
Morristown, New Jersey

FMC East Orange  
East Orange, New Jersey

Robert Motacki  
Administrator  
DCI North Brunswick  
North Brunswick, New Jersey

Kenneth Noonan  
Hemodialysis Patient  
Neptune, New Jersey

Linda Powell, RD  
Renal Dietitian  
DCI Princeton  
Princeton, New Jersey

Robert Rigolosi, MD  
Nephrologist  
Holy Name Hospital  
Teaneck, New Jersey

Carlos Rivera, MD  
Nephrologist  
FMC San Juan  
San Juan, Puerto

Paula Ruiz de Somocurio, RN  
Administrator  
Hackensack Medical Center  
Hackensack, New Jersey

Marien Saade, MSN, CNN  
Administrator, Lifelink  
San Juan, Puerto Rico

Judith Scerbo  
Regional Director  
DVA Dialysis Centers, NJ

Judith Semptimphelter  
Area Administrator  
FMC Medical Care  
New Jersey

Richard Sherman, MD  
Nephrologist  
Robert Wood Johnson U MC  
New Brunswick, New Jersey

Ronald Zanger, MD  
Nephrologist  
DVA Cherry Hill  
Cherry Hill, New Jersey

Suzanne Juliano, RN  
Administrator  
Holy Name Hospital  
Teaneck, New Jersey

The Council met one time. Comparative data on local and national goal attainment were discussed and the following educational programming about new technology and areas of clinical relevance was provided. The meeting was held on October 22, 2008, at the Sheraton Woodbridge Place, Iselin, New Jersey. Topics and speakers were:

<i>Quality Improvement</i>	Toros Kapoian, MD <i>President, Board of Trustees</i>
<i>Understanding Disparities in CKD: The Way Forward</i>	Keith Norris, MD <i>Vice President of Research Charles Drew University of Medicine &amp; Science Hospital</i>
<i>Hyperphosphatemia</i>	Paul Fine, MD, FACP <i>Medical Director Morristown Memorial Hospital</i>
<i>Hypertension Management: And Now for Something Completely Different</i>	Barry A. Eppinger, DO <i>Internal Medicine and Nephrology Morristown Memorial Hospital</i>

Presentation of the *Ahmet B. Ahmet Award* to a consumer elected by the Boards from the many deserving nominations submitted by facility staff was a meeting highlight.

***Fistula First Commendation Awards were given to two facilities for*** achieving from 2004 to 2008 the highest rate of hemodialysis catheter access reduction during the Fistula First Breakthrough Initiative. The awards were given to: DaVita Edison Dialysis Center in New Jersey and BMA Carolina Dialysis Center in Puerto Rico.

East Orange General Hospital Administration, as well as patients and staff of the East Orange General Hospital Dialysis Center were given an award for achieving from 2006 to 2008 significant progress in improvement of patient care delivery systems and patient care outcomes.

Facility staff are invited each year to highlight specific internal quality projects for the benefit of all meeting participants. Eleven posters were displayed at the annual meeting:

**East Orange General Hospital**

*Intervention of a Protein Modular During Dialysis Treatments Helps to Improve the Nutrition Status of Patient.* Natalie Roberts-Moore, MS, RD, Padmaja Kodali, MD, Nieves Galgo, RD, Esther Adesina, MS, RD.

**East Orange General Hospital**

*Outcome of Intravenous Ferrlecit Therapy in Dialysis Patients with High Serum Ferritin and Low Serum Transferrin Saturation in Improving Hemoglobin and Decreasing the Epogen Dosage.*

Lolita Yap, BSN

Bhargavi Tangirala, MD, Padmaja Kodali, MD.

**FMC Regional Office**

*Social Work Monthly Patient Education Program,* Jessica Phipps, MSW, LCSW

**East Orange General Hospital**

*Outlining Factors That Have Assisted the Facility in Significantly Increasing the Number of Patients on the Transplant Wait List and Actual Transplant's Since 2006.* Patricia Allman Koontz, RN, MaryAnne Lund, MSW, LCSW, C-ASWCM, Marie Gerace, MSW, LCSW, LICSW

**Morristown Memorial Hospital**

*Does Longer Treatment Time Improve Dialysis Adequacy?* Mary Buckley-O'Dell, MBA, RN, CNN, Madeline McLoughlin, BSN, CNN, Kathleen Vnenchak, BSN, CNN, Phoebe Aliparo, BSN, CNN

**Our Lady of Lourdes Medical Center**

*Fluid Management*, Maureen Vassie RN, CDN

**Parkside Dialysis Center**

*Is Phosphorus Control Possible?* Ling Chang, MSN, CNN, Josephine Recio, MS, RD, Josephine Domingo, BSN, CNN, Nenita Mancenido, BSN

**Riverview Medical Center Dialysis**

*Fistula First Initiative*, Vimla Christian, RN, CNN

**Robert Wood Johnson University Hospital**

*The Positive Effects of Intravenous Ascorbic Acid on Both Adult and Adolescent Patients Receiving Chronic Hemodialysis Therapy.* Sarah Tomasello, PharmD, BCPS, Lynne Weiss, MD, Debbie Breese, RN, Garletha Allen, BSN, CNN, Dan el Pieloch, MSRD, Robin Roberts, RN, CNN

**The Valley Hospital**

*The Multi-Disciplinary Team Approach to Managing Phosphorus.* Kate Scherr, RD, Wendy Caserta, RD  
Michelle Mandi-Makovsky, RPH

**St. Joseph Medical Center**

*Phosphorus Management*, Kristen Fazio, RD, BS, Rachel Albaum, RD, BS, Padmaja Parthasarathy, RD, BS, Nancy Picinich, RD, BS

**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: twelve (12) 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 two patient representatives. All of the members are engaged in ESRD treatment.

The 2008 Medical Review Board was composed of two consumers, one registered dietitian, one social worker, two nurse administrators, one registered nurse and six physicians. One member was from Puerto Rico and the remainder from New Jersey. The following chart illustrates the Medical Review Board's composition.

Type of Facility	North NJ	South NJ	Puerto Rico
Hospital-based	3 physicians	1 dietitian 1 physician	
Non-profit satellite	1 nurse		
Corporate provider	1 nurse	1 social worker 1 physician 1 nurse	1 physician
Patient	1 patient	1 patient	

Members included:

Paul Fine, MD- Chairman Nephrologist Morristown Memorial Hospital Morristown, New Jersey	Sadanand Palekar, MD Program Director of Pancreas and Renal Transplant Program Newark Beth Israel Medical Center Newark, New Jersey
Rosemary Acuna, RN Patient Representative Newark Beth Israel Medical Center Newark, New Jersey	Josue Castresana, MD Nephrologist Cayey Dialysis Center Cayey, Puerto Rico
Joseph Albanese, MD Nephrologist Jersey Shore Medical Center Neptune, New Jersey	Arlene Paquet, RN Administrator Valley Fairlawn Dialysis Center Fairlawn, New Jersey
Ira Strauss, MD Nephrologist DaVita Freehold AKC Manalapan, New Jersey	Patricia Madden, RN Administrator Shining Star DaVita Neptune Neptune, New Jersey
Cori Nunziata, LSW Social Worker DCI North Brunswick Dialysis Ctr North Brunswick, New Jersey	Padmaja Kodali, MD Nephrologist East Orange General Hosp. DC East Orange, New Jersey
John O'Grady Patient Representative Piscataway, New Jersey	Kathy Searson, RN Peritoneal Dialysis DCI North Brunswick DC North Brunswick, New Jersey
Sheri L. Dubinsky, RD, CSR Dietitian RCG Renal Institute Toms River, New Jersey	

The Board of Trustees accepted nominees for election to the Medical Review Board from active organizational members. An individual must have demonstrated high quality of medical care and an ability to evaluate the quality and appropriateness of care delivered to renal failure patients to serve on the Medical Review Board.

The Medical Review Board has the responsibility for the development of criteria and standards for evaluation of care; review of facility protocols for patient modality selection; review of patient grievances as necessary, according to standard procedures adopted by the Board; development of protocols for individual case review; evaluation of existing available services and recommendations for the addition of alternative services as needed; the analysis of facilities' compliance with Network goals and recommendations for improvement.

No person serving on the Medical Review Board had responsibility for review of any case in which he or she has, or had, any professional involvement, received reimbursement or supplied goods. No person serving on the Medical Review Board with a financial interest, direct or indirect, in a facility furnishing ESRD services reviewed the ESRD services of that facility. Confidentiality assurances were utilized by the Medical Review Board to protect the rights of consumers, providers, and facilities.

The 2008 activities included review of facility-specific data, reports of the Clinical Performance Measures project, lab data collection for the last quarter of 2007, Fistula First Breakthrough Initiative reports, and other data from CMS. There were no patient grievances to review.

The 2008 Medical Review Board meeting dates and locations were:

March 12 - Forsgate (Jamesburg, NJ)	June 11 - conference call
September 10 - Forsgate (Jamesburg, NJ)	December 3 - conference call

## BOARD OF TRUSTEES

The Board of Trustees consisted of fourteen (14) members. Upon resignation of a member, inability to complete a term of office, or non-attendance at two (2) consecutive board meetings, the position would be deemed vacant and filled by a new member selected by the president of the board. The new member then would serve for the unexpired term held by the member whose position he or she filled.

The Board elected from among its membership the following officers: president, vice president, secretary and treasurer. The president served as the president of the board and chairman of the Council, and monitored all Network operations with the project director. The vice president presided or acted in the absence of the president. The secretary was responsible for keeping minutes of all board meetings and assured proper maintenance of all records and reports (except financial) for the Council. The treasurer was responsible for reporting the financial status and budget preparation of the Council.

The Board of Trustees was composed of two consumers, one dietitian, one social worker, two administrators, two nurses and six physicians. In order to more completely review vascular access a surgeon was invited to join the Board. Two board members were from Puerto Rico, one from the Virgin Islands with the remainder from New Jersey. The chart below shows the Board's composition.

Type of Facility	North NJ	South NJ	Puerto Rico	Virgin Islands
Hospital-based	1 administrators 2 physicians	1 physician		1 physician
Non-profit satellite				
Corporate provider	1 social worker 1 administrator	1 dietitian 2 physicians	2 nurses	
Patient		2 patients		

### Members Included:

Toros Kapoian, MD- President Robert Wood Johnson U MC New Brunswick, New Jersey	Marien Saade, RN, MSN, CNN LifeLink de Puerto Rico Guaynabo, Puerto Rico	Judy Semptimphelter, RN Area Administrator Fresenius Medical Care, NJ
Alexandre Ackad, MD Nephrologist Hackensack University MC Hackensack, New Jersey	Ron Zanger, MD Nephrologist DVA Cherry Hill Cherry Hill, New Jersey	Wishburne Hunte, MD Nephrologist Roy Schneider Hospital St Thomas, VI
Jennifer Kurzawa, RD Renal Dietitian DVA Old Bridge Old Bridge, New Jersey	Michael Conrad, MD Nephrologist DVA Burlington Lumberton, New Jersey	Paula Ruiz de Somocurio, RN Administrator Hackensack Medical Center Hackensack, New Jersey
Mary Lorenzo, MSW Patient Representative Matawan, New Jersey	Phyllis Micchelli, MSW Social Worker FMC East Orange East Orange, New Jersey	Chandra Chandran, MD Nephrologist St. Joseph's Medical Center Paterson, New Jersey



Kenneth Noonan  
Patient Representative  
Neptune, New Jersey

Pascual Muniz, RN  
Regional QI Manager  
Fresenius Medical Care  
Mayaguez, Puerto Rico

The election of officers took place at a regularly scheduled meeting of the Board. Election of officers was by simple majority of those members present and voting.

The Board monitored and directed the daily operation of the Network organization. The board has the authority to:

- Employ and terminate any personnel required for the business of the Network;
- Prepare a plan which defines Network goals, objectives and implementation of objectives;
- Prepare an evaluation methodology to measure progress;
- Develop Network operating and governing policies and procedures;
- Suggest alternative approaches to meeting goals and objectives for the Network's consideration;
- Review and update the Network plan on a regular basis;
- Review all fiscal matters of the Network and review records on such matters, which include, but are not limited to, the collection and disbursement of all funds;
- Certify the representatives for appointment to the Council, and keep up-to-date records of the membership of the Council;
- Appoint members and designated alternates to the Medical Review Board; and
- Review the By-Laws, amending them when necessary.

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.

The 2008 Board of Trustees meeting dates and locations were:

March 26 - Forsgate (Jamesburg, NJ)  
June 24 - conference call

September 24 - Forsgate (Jamesburg, NJ)  
December 17 - conference call

## **PATIENT ADVISORY COMMITTEE**

The Patient Advisory Committee (PAC) was organized in 2006 with patient volunteers from throughout New Jersey. The mission of the Patient Advisory Committee is to support the mission of the Trans-Atlantic Renal Council 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 TARC'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 and actively participate in the development of patient education programs and the PAC newsletter, *Kidneys R Us*.

The committee held its first meeting on September 28, 2006, when members reviewed and discussed the goal statement, member agreement, and the conflict of interest statement. A logo was selected and a plan for the patient newsletter entitled *Kidneys R US* was formulated. At subsequent meetings the group

formatted the newsletter, adopted a logo, and agreed upon these initial articles for publication: *What is the Patient Advisory Committee?*, *Ahmet Ahmet Rehabilitation Award Winner* and *What is TARC?* Additional information included the TARC toll free number and how to join the PAC. Membership was open to all patients, family members and interested parties.

In 2008, the committee refined the content for the PAC newsletter, which was distributed in January, May and August 2007 and in April, September and December 2008 respectively. The newsletters were written in English, translated into Spanish and distributed to all facilities in New Jersey, Puerto Rico and the US Virgin Islands.

The Committee reviewed and developed future goals at the May 30, 2008, meeting and unanimously agreed upon the following goals for the committee.

1. Develop and distribute a one page newsletter four times each year or one every quarter;
2. Increase active membership of the PAC committee by 10%;
3. Assist the NJ Renal Coalition with development of patient education programs;
4. Assist TARC with the redevelopment of the life changes, treatment choices and the resources and links categories of the consumer Web site;
5. Assist with promoting educational materials and resources for ESRD patients;
6. Facilitate and improve communication between consumers and facility staff; and
7. Assist TARC with beneficiary-related activities.

To date, the following has been accomplished: the newsletter was published quarterly and the active membership increased by 22%. The committee will continue to collaborate with the NJ Renal Coalition for patient education programs and information.

The PAC committee collaborated with the New Jersey Renal Coalition to review and determine patient educational handouts and materials for the patient education programs that were held on May 22 and October 11, 2007, and on June 17 and November 13, 2008, about secondary hyperparathyroidism, vascular access and fear of cannulation. The chart below shows the PAC composition.

Modality	North NJ	South NJ	Puerto Rico/VI
Hemodialysis	5	6	1
Peritoneal dialysis	0	2	
Transplant	3	0	
Spouse	1	1	

Membership included:

Terence Boyle  
Elmwood Park, New Jersey  
Transplant

Terry L. Hewitt  
Fairton, New Jersey  
Hemodialysis

Morrell, Ms. Denise  
Sparta, New Jersey  
Hemodialysis

Beverly A.Causby  
Asbury Park, New Jersey  
CAPD

Alan Hoffman  
Glen Rock, New Jersey  
Hemodialysis

Kenneth Noonan  
Neptune, New Jersey  
Hemodialysis

John DiFabio  
Harrington Park, New Jersey  
Transplant

Heddi Hoffman  
Glen Rock, New Jersey  
Spouse

John O'Grady  
Piscataway, New Jersey  
Hemodialysis

Susan Esposti  
Mercerville, New Jersey  
Hemodialysis

Joseph Jean-Mary  
Roselle, New Jersey  
Transplant

Constance O'Grady  
Piscataway, New Jersey  
Spouse

Rose Forte  
Freehold, New Jersey,  
Hemodialysis

Kye Martin  
Christiansted, US VI  
Hemodialysis

Sakhu, Mr. Abubakr  
Bartonsville PA  
Hemodialysis

Franklyn C. Hall  
Salem, New Jersey  
Hemodialysis

Margaret Matulewioz  
Neptune, New Jersey  
CAPD

Sabrina Sims  
Bloomfield, New Jersey  
Hemodialysis

Mani Swaminathan  
Lakewood, New Jersey  
Hemodialysis

The 2008 Patient Advisory Committee meetings were held at Healthcare Quality Strategies in East Brunswick on the following dates:

January 29  
September 16

May 13  
November 18

TARC held the first patient education program in Puerto Rico on September 30<sup>th</sup>. The program included information about vascular access, patient rights and responsibilities and the role of the Network. Three of the patients indicated they were interested in joining the committee and participating via conference calls.