Quality Insights Renal Network Three

2011 ANNUAL REPORT

Quality Insights
Renal Network 3

Serving ESRD patients in New Jersey,
Puerto Rico and the U.S. Virgin Islands.

Contract Number: 500-2010-NW003C, June 30, 2012

Submitted to: Kathleen Egan, Project Officer, CMS/Division of Quality Improvement, Boston, MA
Submitted by: Quality Insights Renal Network 3, 109 South Main Street, Suite 21, Cranbury, NJ

I. PREFACE

Quality Insights Renal Network 3 is pleased to present its 2011 ESRD Annual Report. 2011 was an exciting and challenging year for QIRN3. We continued working to decrease the number of patients who use catheters as their primary access, reducing the rate of healthcare acquired infections in dialysis providers, and acting as an independent investigatory resource for patients who have concerns, complaints, or grievances about their dialysis provider.

In 2011, we saw many clinical care and quality improvement successes. This includes continued progress toward the CMS goal of 66% of patients utilizing an arteriovenous fistula (AVF) for their dialysis treatment. In 2011 QIRN3 improved its fistula rate from 57.0% to 59.1% of patients now using this preferred access method. New Jersey dialysis units in particular have worked extremely hard on this project, achieving a fistula rate of 62.1% by December 2011.

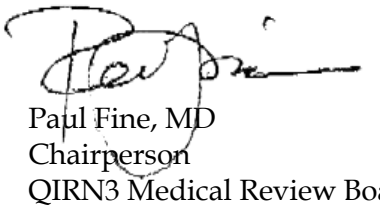
At the direction of its Medical Review Board and Board of Directors, we have been working on reducing the inappropriate use of catheters since 2005. This important initiative remained one of the projects that we continued to focus on during 2011, with a particular emphasis on those catheters in use for more than 90 days.

We continued working with the Centers for Disease Control and Prevention (CDC) in 2011 to reduce the incidence of Healthcare Acquired Infections (HAI) in outpatient dialysis providers. Our staff attended several meetings held by the CDC Hemodialysis Collaborative and continued to work closely with CDC experts to plan the rollout of the initiative to providers in New Jersey, Puerto Rico, and the US Virgin Islands. By the end of 2011, 95% of dialysis providers in Network 3 registered and began reporting data to the CDC/NHSN data system.

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

Toros Kapoian, MD
Vice-Chairperson
QIRN3 Board of Directors



Paul Fine, MD
Chairperson
QIRN3 Medical Review Board

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].

[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.

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 90 patients in each dialysis unit and Puerto Rico treats an average of 117.7 patients in each unit, compared to an average of 70.8 nationwide. The US Virgin Islands treats an average of 69.3 patients in each of its 3 dialysis units.

Population Distribution

The following table shows ESRD incidence rates for 2011 based on data from the Standard Information Management System (SIMS), 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* 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.

Table A 2011 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	3,545	403
Puerto Rico	3,725,789	12.4	75.8	12.8	1,446	388
US Virgin Islands***	106,405	76.2	13.1	9.1	50	456
Network	12,627,257	13.8	70.2	10.2	5,069**	401
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 SIMS Patient Registry 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*

Incident ESRD Patient Population in Network 3

In calendar year (CY) 2011, 5,069 patients began treatment for ESRD in Network 3, 194 (3.9%) more than in CY 2010. Every state and territory in the Network 3 area has a higher ESRD incidence rate per million than the US overall. While the national incidence rate per million is 367, the incidence rate per million in the Network overall is 401, the rate in New Jersey is 403, the rate in Puerto Rico is 388, and the rate in the US Virgin Islands is 403. The average age of an incident ESRD patient in New Jersey is 65.7, in Puerto Rico it is 63.1, and in the USVI it is 60.9. Please refer to Table 1 in the appendix of this report for a complete analysis of the incident ESRD population by age, gender, race, and primary diagnosis.

Prevalent Dialysis Patient Population in Network 3

By the end of CY 2011, 17,314 patients were receiving dialysis treatment for ESRD in Network 3, 717 patients (4.3%) more than CY 2010. 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 35.3%. Puerto Rico and the US Virgin Islands in particular have experienced a dramatic rise in the number of prevalent patients being treated, with 45.2% and 61.8% 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 (117.7) of patients than the US (70.8) in each dialysis center. While dialysis centers in the US Virgin Islands (USVI) on average treat slightly fewer (69.3) 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 is approaching 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
2002	9,292	--	3,366	--	136	--	12,794	--
2003	9,597	3.2	3,484	3.5	135	-.7	13,216	3.3
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
10 Year % Increase		**31.4**		**45.2**		**61.8**		**35.3**

Source: Network 3 SIMS Database

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, 2011, there were 213 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.

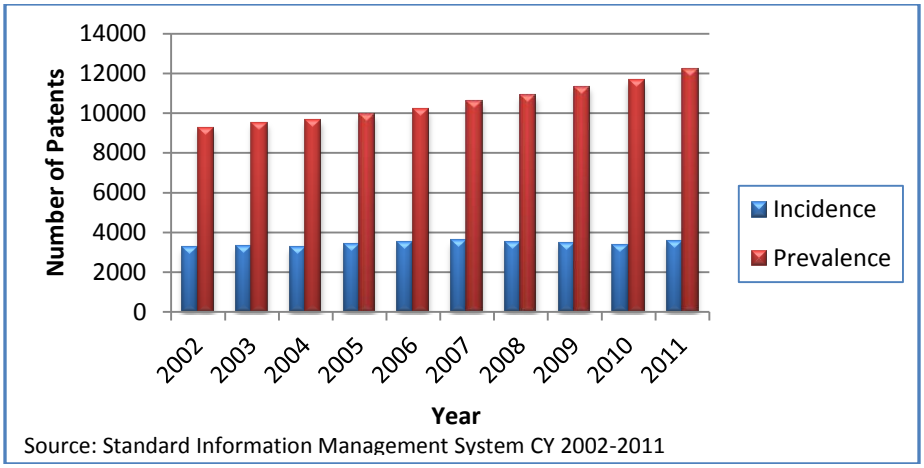
The epidemic of diabetes in Puerto Rico continues to be the leading cause of end stage renal disease in this area. Among incident cases, 65.1% reported a primary diagnosis of diabetes, and diabetes is reported as the primary diagnosis in 60.1% of prevalent patients. As a comparison, in New Jersey diabetes is

[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.

reported as the primary cause of renal failure in 43.7%% of incident patients and 42.3% of prevalent patients.

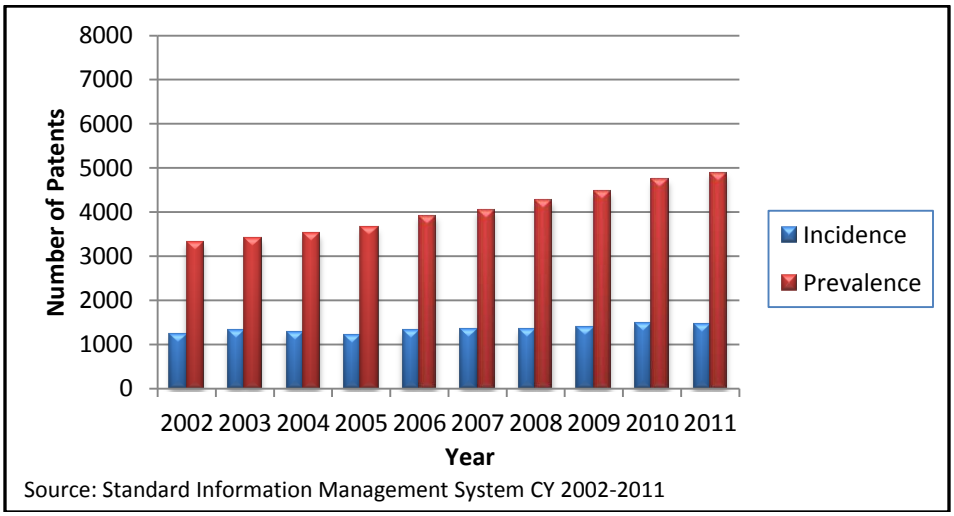
Please refer to Table 2 in the appendix of this report for a complete analysis of the prevalent ESRD population by age, gender, race, and primary diagnosis.

Figure 1: Annual Incident and Prevalent Patients in New Jersey - CY 2002-2011



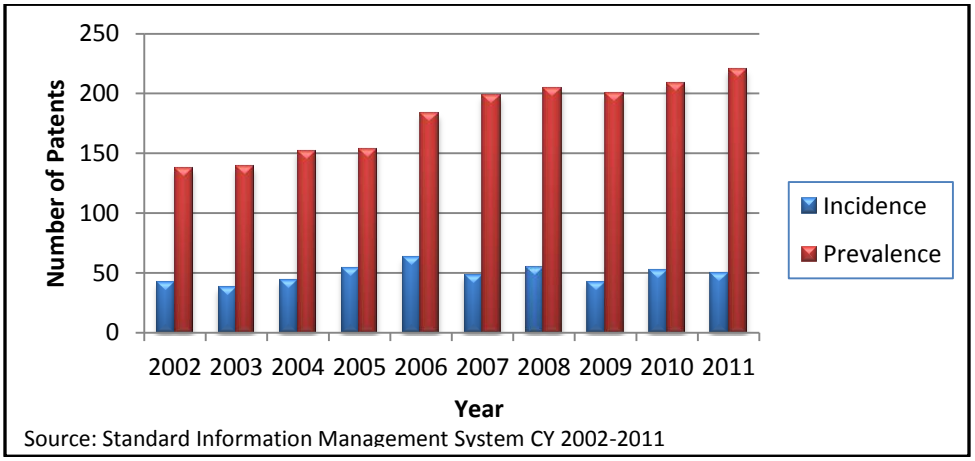
Source: Standard Information Management System CY 2002-2011

Figure 2: Annual Incident and Prevalent Patients in Puerto Rico - CY 2002-2011



Source: Standard Information Management System CY 2002-2011

Figure 3: Annual Incident and Prevalent Patients in Virgin Islands - CY 2002-2011



Mortality Data

Death notification reports for ESRD consumers are analyzed by sex, race, and cause of death. The primary cause of death reported in 2011 continued to be cardiac (42%), which again reflected national data. Infection was reported as primary cause in 19% of the 3,694 death records received. Of all deaths reported in 2011, 69.2% were white, 23.7% black; 58.3% were male, 41.7% female.

As will be detailed later in this report, infections are 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 29.4% of the 1,150 death records received, compared to just 14% in New Jersey. Although New Jersey has a prevalent population that is almost 2.5 times greater than that of Puerto Rico, an almost equal number of patients (350 in New Jersey, 338 in Puerto Rico) died due to infection in each of these areas.

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.

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 2011, 440 transplants were performed in New Jersey at five federally certified ESRD renal transplant centers, a 3.7% decrease from the 2010 total of 457 transplants.

The number of consumers on a transplant waiting list in New Jersey as of December 2011 increased to 1,236, from 1,213 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 2011, 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 5 dialysis patients were able to receive transplants at off-island transplant centers in 2011, up from only 2 patients in 2010. Additionally, 135 patients dialyzing in New Jersey and 9 patients dialyzing in Puerto Rico received transplants in other states.

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, 2002-2011

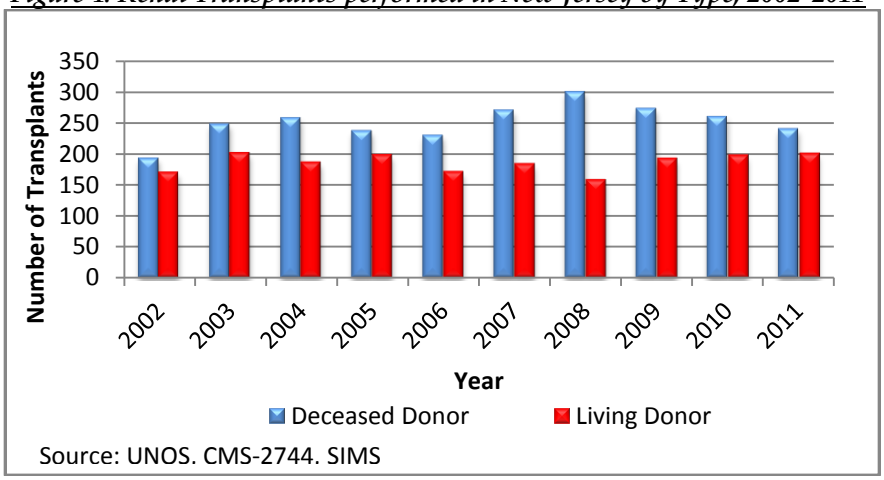
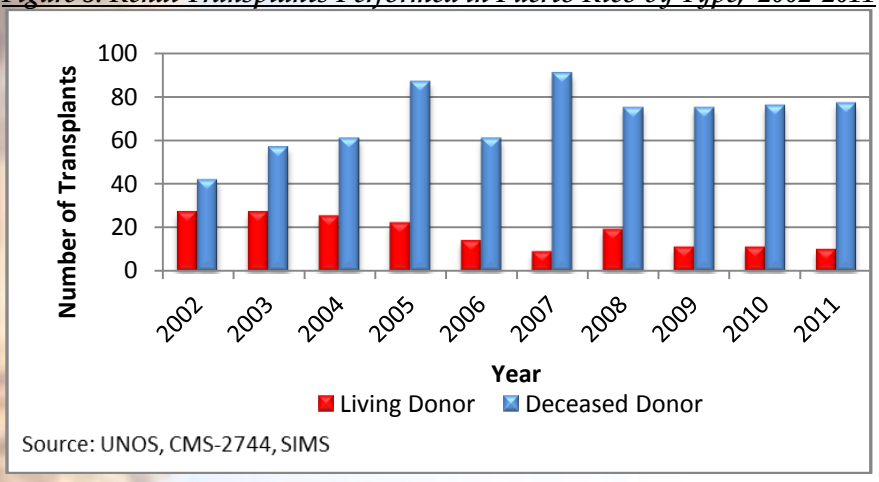


Figure 5: Renal Transplants Performed in Puerto Rico by Type, 2002-2011



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

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

Chris Milkosky, MBA, 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

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.

Tricia Phulchand, BS, Office Manager

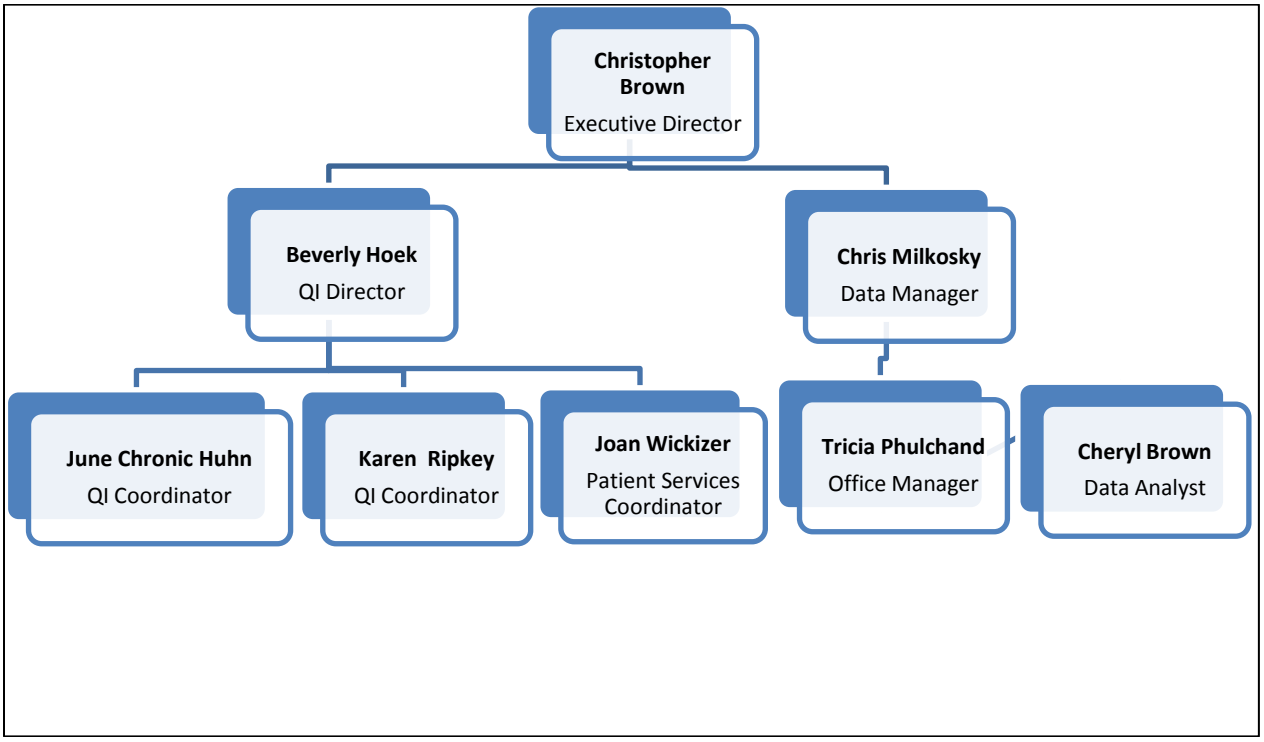
- Provided administrative support to all staff
- Supervised data clerk
- Monitored all project submissions as well as assisted in the implementation of facility testing of CROWNWeb
- Monitored complete and timely data submission
- Assisted in meeting arrangements, supervised all bulk mailings and supported QI activities

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. The Data Manager resigned his position in October 2011, and QIRN3 leveraged its relationship with members of its corporate family, including ESRD NW 5, to fulfill the duties of the Data Manager during this absence.

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 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. 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 branch and the Puerto Rico and U.S. Virgin Island 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 2011, New Jersey Members included:

Members (137)	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
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

Members (137)	Title	Location
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
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

Members (137)	Title	Location
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
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

In 2011, Puerto Rico (48 total) and the U.S. Virgin Islands (6 total) members included:

Members	Title	Location
Louis Acevedo	FMC Regional Mgt	San Juan< PR
Daisy Baez	Administrator	Cayey, PR
Monica Bet	Head Nurse	St. Thomas, USVI
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
Gala Garcia	Administrator	St.Thomas, USVI
Wishburne Hunt	Nephrologist	St. Thomas, USVI
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
Larry McGowan	Administrator	Christiansted, USVI
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
Ivette Rodriguez	Administrator	St. Croix, USVI
Rosa Rodriguez	Administrator	Santa Juanita, PR
Sandra Rosario	RN	Guaynabo, PR

Members	Title	Location
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.

2011 members included:

Chairperson	Title	Location
Paul Fine	Nephrologist	Morristown, NJ
Members	**Title**	**Location**
Sadanand Palekar	Nephrologist	Newark, NJ
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
Magy Milfort	FNP, FMC DO	Matawan, NJ
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 2011in Baltimore and was on a patient panel. She contributed her story to help personalize the needs of the dialysis patients to CMS, Quality Improvement Organization (QIO) and ESRD Network staff.

2011 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
Cecil Grizzard	Hemodialysis	West Deptford, NJ
Leon Haines	Hemodialysis	Marlton, 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

Members	Modality	Location
William Reineman	Hemodialysis	Hoboken, NJ
William Senior II	Hemodialysis	Trenton, NJ
Michael Smith	Hemodialysis	Cherry Hill, NJ
Mani Swaminathan	Hemodialysis	Brick, NJ
Anna Szonyi	Hemodialysis	Newton, NJ
Annie Wilson	Hemodialysis	Cherry Hill, 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 & safety of dialysis-related services provided for those with ESRD

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 1.7 percentage points
   b. Decrease the percentage of catheters> 90 days by 1 percentage point with a stretch goal of 1.5 percentage points
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. Ninety percent of Network facilities will complete registration in the CDC National Healthcare Safety Network
   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

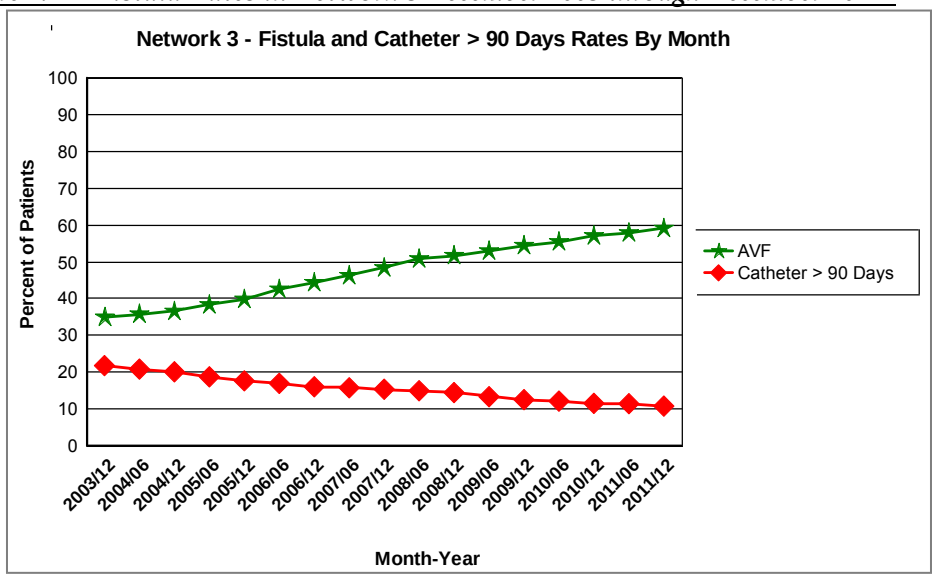
Task 1 - Vascular Access (FFBI)

a. Increase the percentage of AV fistulas by 1.7 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. *Figure* illustrates the improvements in the rate of AV fistulas used in Network 3 from December 2003 through December 2011.

Figure 7: AV Fistula Rates in Network 3 December 2003 through December 2011*



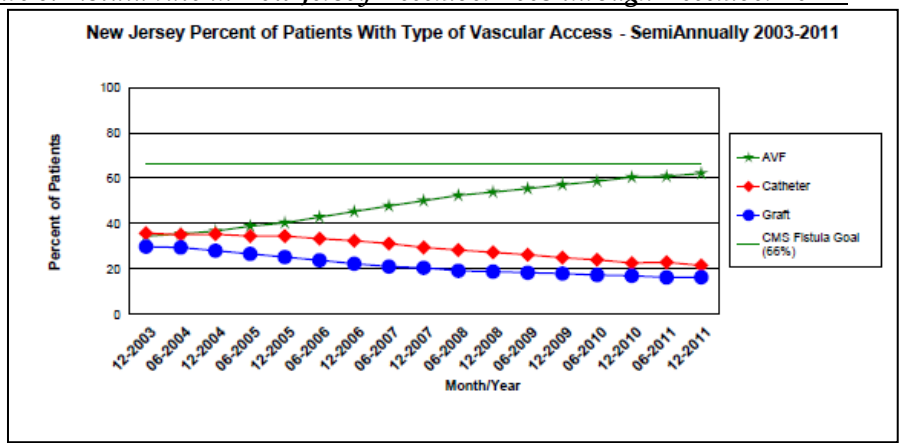
***Source Fistula First Dashboard**

Goal: Increase the prevalent AVF rate by 1.7 percentage points by March 2012

Project Results: Each year the Network was challenged by CMS to achieve an established goal. During 2011, the Network's goal was to increase the prevalent AV fistula rate by 1.7 percentage points by March 2012. According to the March 2012 data, Network 3 achieved the CMS goal.

Figure 8 demonstrates the improvement in New Jersey's AV fistula rate from December 2003 through December 2011. The fistula rate in New Jersey was 62.1% as of December 2011.

Figure 8: Fistula rate in New Jersey December 2003 through December 2011*

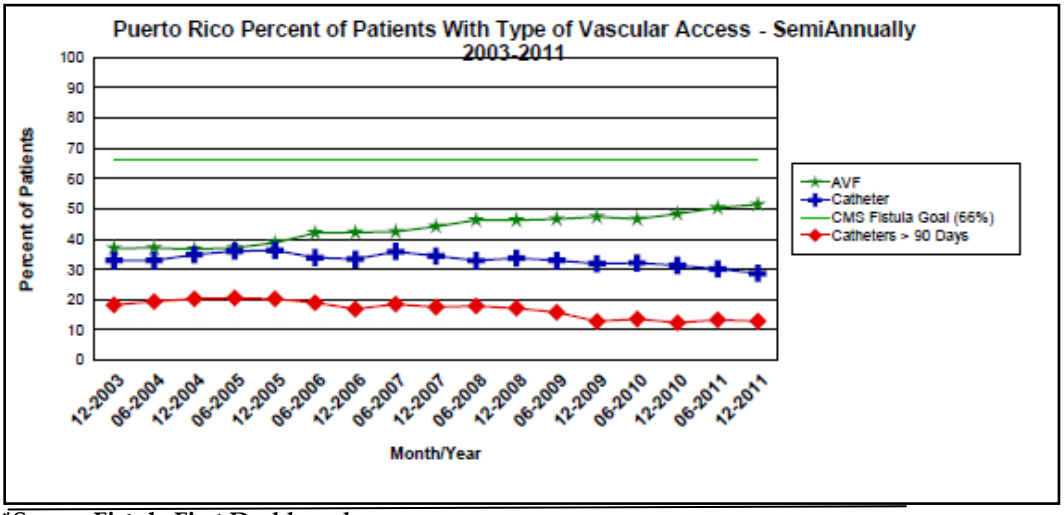


***Source Fistula First Dashboard**

Figure demonstrates the improvement in Puerto Rico's AV fistula rate from December 2003 through December 2011. The progression has been slow but steady; the December 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.

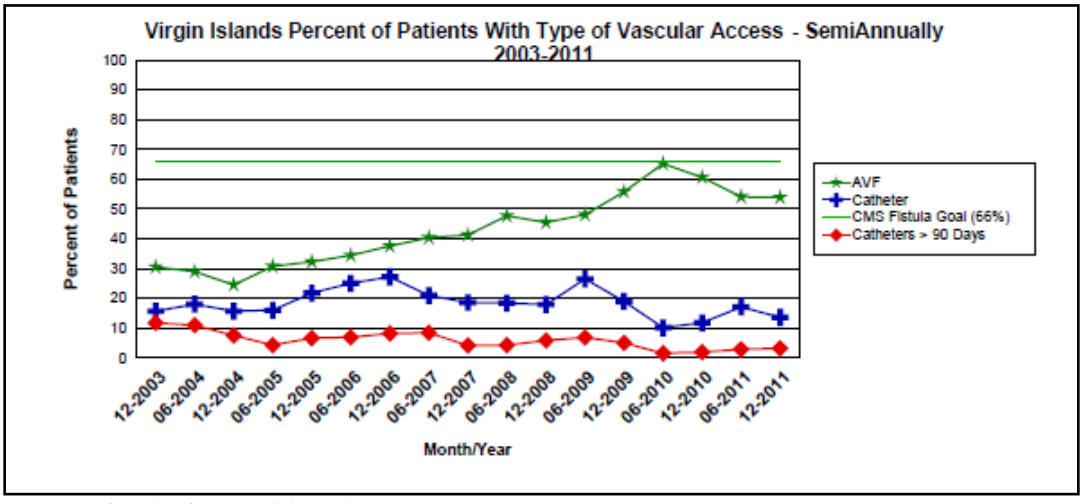
Figure 9: Fistula rate in Puerto Rico December 2003 through December 2011*



***Source Fistula First Dashboard**

Figure 10 below demonstrates the improvement in U.S. Virgin Island's AV fistula rate from December 2003 through December 2011. The sudden decrease in fistula rates beginning in late 2010 was due to local politics and reimbursement issues related to Medicaid patients.

Figure 10: Fistula rate in U.S. Virgin Islands December 2003 through December 2011*



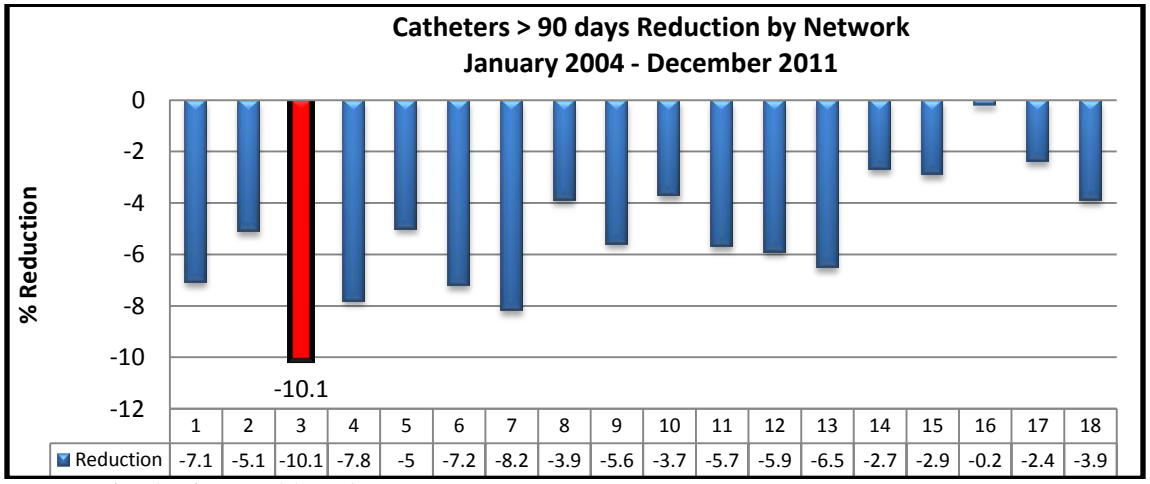
***Source Fistula First Dashboard**

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, 2011 for catheters > 90 days was a 1 percentage point reduction with a 1.5 percentage point stretch goal. The NW baseline in March 2011 was 12.0%. As of December 2011 data, the catheter > 90 days rate in New Jersey had been reduced 1.2 percentage points, Puerto Rico saw a 0.6 percentage point reduction and the U.S. Virgin Islands decreased the catheter > 90 days rate by 1.6 percentage points.

Figure 11 shows the reduction in catheters > 90 days by Network from January 2004 through December 2011. In these seven years, Network 3 has decreased this clinical measure by 10.1 percentage points.

Figure 11: Catheter > 90 Days Reduction by Network January 2004 through December 2011*

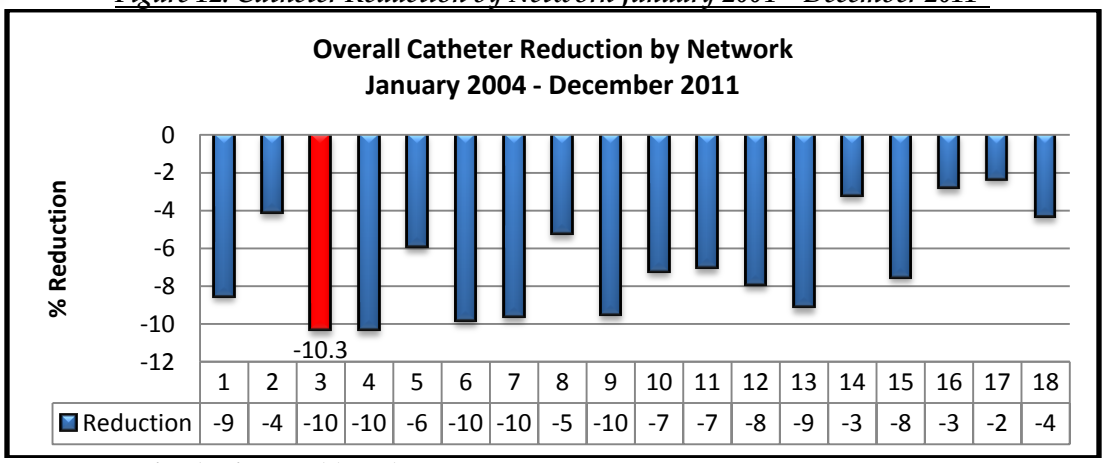


***Source Fistula First Dashboard**

Catheter Reduction

Project Results: In 2007 the Network Medical Review Board and Board of Directors challenged the dialysis facilities to decrease the prevalent catheter rate annually. As of December 2011, Network 3 has reduced the use of catheters by 10.3 percentage points as shown in Figure 12.

*Figure 12: Catheter Reduction by Network January 2004 – December 2011**



**Source Fistula First Dashboard*

Of 169 hemodialysis providers in Network 3, 25 (15%) have achieved >70% AVF rate, while an additional 49 (30%) have achieved the CMS goal of 66%. This represented a 26% increase in the number of facilities achieving the CMS goal in the last 12 months. A total of 128 facilities have an AVF rate of at least 51% as of December 2011.

Facilities with fistula rates between 51 and 65.9% demonstrated minimal improvement between 2010 and 2011. A root cause analysis showed that 14 of these 79 facilities are in Puerto Rico where the fistula rates have increased from the 40% range to the 50% range. Eleven of the facilities are hospital satellites or hospital-based facilities where the majority of incident patients begin dialysis. The remaining 54 units will be the focus of targeted intervention in 2012.

Figure 13: 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
30.9% or less	1	16
31%-40.9%	10	776
41%-50.9%	30	2,919
51%-65.9%	79	8,059
66%-70.9%	24	2,092
71%-80.9%	22	2,092
81%-100%	3	232
Total Number of Providers	169	16,186

Source: Provider vascular data reports December 2011

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. Each month the QI staff analyzes the progress to goal reports created by the data manager. This report allows the team to rapidly identify and intervene with facilities that have gone off course.

In 2011 the Fistula First Dashboard included data that allowed National rankings to be generated for all hemodialysis facilities based on current fistula rates. The Network incorporated this data by reporting the facility's national ranking as part of the quarterly vascular access report. Facilities ranking in the top 10% nationally were contacted for approval and then recognized at the Network's annual education program.

The facility specific goals are reported in the quarterly vascular reports and in 2011 included overall catheter reduction from January through June and reduction of catheters > 90 days July through December. At the July 2011 Board meetings the members discovered that NW3 had the highest catheter > 90 days rate in the Nation.

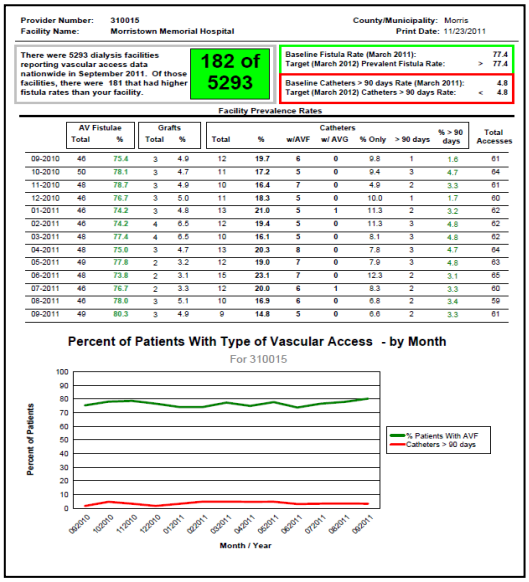
Nephrologist Specific Data

In 2010, the Networks were given patient-specific vascular access data from all the large dialysis organizations (LDO). The Executive Director combined the patient/nephrologist data available in SIMS to the patient specific vascular access data and provided the QI staff with physician specific vascular access data. Analysis of the 2011 data revealed that 24 physicians in Network 3 had greater than 50 patients and a catheter > 90 days rate higher than the Network average (11.4%). Thirteen physicians were from Puerto Rico and 11 were from New Jersey.

Since the data reflected only that of the LDOs, the Network felt that practice patterns most likely would be consistent regardless of facility ownership, so if a physician had a high catheter count in the LDO facilities, his/her catheter rate would likely be high at the independent facilities.

QIRN3 has no jurisdiction over the individual nephrologists; therefore, the Network lacks the ability to enforce goal attainment. The hope was that by drawing attention to individual rates the physicians would decrease the number of patients utilizing a catheter as the primary access.

The initial letter contained quarterly interim goals with a 10% reduction goal in one year.



Provider Number: 310015 County/Municipality: Morris
Facility Name: Morristown Memorial Hospital Print Date: 11/23/2011

There were 5293 dialysis facilities reporting vascular access data nationwide in September 2011. Of those facilities, there were 181 that had higher fistula rates than your facility. **182 of 5293**

Baseline Fistula Rate (March 2011): 77.4
Target (March 2012) Prevalent Fistula Rate: > 77.4

Baseline Catheters > 90 days Rate (March 2011): 4.8
Target (March 2012) Catheters > 90 days Rate: < 4.8

Facility Prevalence Rates

	AV Fistulae		Grafts		Catheters						Total Accesses
	Total	%	Total	%	Total	%	w/AVF	w/ AVG	% Only	> 90 days	% > 90 days	
09-2010	46	75.4	3	4.9	12	19.7	6	0	9.8	1	1.6	61
10-2010	50	78.1	3	4.7	11	17.2	5	0	9.4	3	4.7	64
11-2010	48	78.7	3	4.9	10	16.4	7	0	4.9	2	3.3	61
12-2010	46	76.7	3	5.0	11	18.3	5	0	10.0	1	1.7	60
01-2011	46	74.2	3	4.8	13	21.0	5	1	11.3	2	3.2	62
02-2011	46	74.2	4	6.5	12	19.4	5	0	11.3	3	4.8	62
03-2011	48	77.4	4	6.5	10	16.1	5	0	8.1	3	4.8	62
04-2011	48	75.0	3	4.7	13	20.3	8	0	7.8	3	4.7	64
05-2011	49	77.8	2	3.2	12	19.0	7	0	7.9	3	4.8	63
06-2011	48	73.8	2	3.1	15	23.1	7	0	12.3	2	3.1	65
07-2011	46	76.7	2	3.3	12	20.0	6	1	8.3	2	3.3	60
08-2011	46	78.0	3	5.1	10	16.9	6	0	6.8	2	3.4	59
09-2011	49	80.3	3	4.9	9	14.8	5	0	6.6	2	3.3	61

Percent of Patients With Type of Vascular Access - by Month
For 310015

Follow-up letters were sent to congratulate physicians who reached the goal or had made significant improvement. Physicians failing to improve were reminded of National Kidney Foundation Kidney Disease Outcome Quality Improvement guidelines and the CMS goal.

An analysis of the December 2011 physician data showed some improvement in the vascular access rates by the physicians in Puerto Rico, but little to no improvement from physicians in New Jersey. The nephrologists from Puerto Rico decreased the overall catheter rate by an average of 3.75 percentage points. Four of the 13 nephrologists in PR showed an increase in the overall catheter rate. Overall, there was a decrease of 0.94 percentage points in the number of patients with a catheter > 90 days.

In New Jersey only 3 of the 11 nephrologists demonstrated a decrease in the catheter rate; they averaged a 6.3 percentage point decrease. However, the remaining 8 nephrologists showed an average increase of 6.5 percentage points. The nephrologists in NJ averaged an increase of 1.25 percentage points in the number of patients utilizing a catheter > 90 days.

There could be several reasons for this difference:

1. The baseline catheter rate in NJ was 24% while the average rate in PR was 38.3%;
2. The baseline catheter > 90 days rate in NJ was 13% while the average rate in PR was 19.3%;
3. The additional attention to catheter reduction related to the infection control initiative in Puerto Rico may have had an impact;
4. The Network has focused more resources in PR than in NJ during 2011.

Medical Director Intervention

The Conditions for Coverage that were released on April 15, 2008 clearly defined the new responsibilities of the Medical Director. Earlier interventions utilized by the Network included the Medical Directors but were more commonly addressed by nursing leadership staff. At the suggestion of the Network Boards the Network has been engaging the Medical Directors at lower performing facilities in their private office instead of at their facility.

Based on analysis of monthly vascular access data, the Boards established selection criteria and targeted for intervention sixteen facilities with <55% AVF rates, a high rate of catheters >90 days, >50 patients, and a failure to achieve and sustain improvement. Sixteen facilities in New Jersey were identified originally but one facility was closed due to flooding from Hurricane Irene.

An appointment was scheduled at the convenience of the Medical Director at his/her private office. Materials reviewed at the meetings included: current and past vascular access data, QIP and proposed changes to the Prospective Payment System, Elab report, Annual Dialysis Facility Report and Supplement, and vascular access management processes. Also discussed were suggestions to enhance improvement and the facility's goal of a three percentage point increase in three months. Eleven Medical Directors were visited in 2011 from July through December. There was sufficient data for seven facilities (baseline and following three months) to demonstrate progress toward the goal of a three percentage point increase in AVF rate.

Data collection and analysis showed that the average baseline AVF rate at the seven facilities was 46%. After three months the average AVF rate increased to 56.5% representing a 10.5 percentage point increase overall. Three of the seven facilities (42%) demonstrated significant

improvement three months after the Network visit. The remaining Medical Directors who have failed to demonstrate sustainable improvement are scheduled to meet with the MRB.

Educational Programs

Multiple educational programs related to the Fistula First Breakthrough Initiative were held during 2011, programs included:

- Annual Meeting on October 13, 2011 included panel discussion of Best Demonstrated Practice presented by two champion facilities in NJ.
- WebEx on August 23, 2011, *Weighted and Unweighted Clinical Scoring*
- WebEx on March 22, 2011, *Infection Control and the Role of Catheter Reduction*
- WebEx on May 20, 2011, *Annual Facility Reports and Implications for 2013-2014 QIP*
- WebEx on May 3, 2011, Lynda Ball, *Improving Buttonhole Cannulation*

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 6 years ago when CMS encouraged Networks to form coalitions and work with others within the healthcare community.

Over the last 6 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 2011:

- QIRN3 has established a Learning and Action Network in Puerto Rico to Decrease Health care Associated Infections and Reduce Catheters. Members include:
  - ANNA Caribbean Chapter
  - LifeLink Foundation – Puerto Rico OPO
  - Auxilio Mutuo – Large metropolitan hospital
  - Puerto Rico Society of Nephrology and Hypertension
  - Puerto Rico Kidney Foundation
  - Veteran's Administration
  - Patient Representative
  - Consejo Renal
- QIRN3 conducted 5 site visits at lower performing facilities in NJ with Fresenius corporate leadership staff, the regional Medical Director and regional PI leadership.
- QIRN3 collaborated with local chapters of ANNA in NJ and present on Network activities at chapter meetings or display data at exhibit tables.
- QIRN3 Quality Improvement Director is a member of the New Jersey QIO - Healthcare Quality Strategies, Inc. Healthcare Associated Infection Advisory Committee
- QIRN3 staff presented a report on Network activities at two DaVita Manager Meetings
- QIRN3 facilitated collaborative engagement between Fresenius corporate leadership and Auxilio Mutuo nursing leadership in Puerto Rico to provide education for ICU staff on how to care for the vascular access in patients with ESRD
- QIRN3 collaborates through monthly conference calls with the New Jersey DOH and the Puerto Rico DOH.

Task 1.b. 2011 ESRD Clinical Performance Measures

Annually, CMS utilizes 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 is completed each year in February

and March, and is based on patient clinical data from October, November and December of the preceding year.

Based on results from the 2010 data collection the MRB established the following Network 3 goals for 2011-2012.

Figure 14: 2011-2012 Network Clinical Goals

Indicator	Goal
Anemia management Hgb 10-12g/dL	63%
Dialysis adequacy URR ≥ 65%	93%
Mean albumin ≥ 4.0/3.7g/dL	36%
Mean TSAT ≥ 20%	88%
Mean phosphorus ≥ 5.5 mg/dL	55%
Mean phosphorus ≥7mg/dL	11%
Prevalent Fistula rate	66%
Catheter reduction (annual)	2%
Incident Fistula rate	50%
Catheters >90 days	<10%

Facility-level statistics provided through the data collection effort 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. Annually, the clinical performance measures report is distributed to each facility to provide comparative clinical data that can be reviewed against facility performance.

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 15. 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: With the approval of the Medical Review Board, the NW initiated a performance scores project to allow 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.

Selection Criteria:

Wave 1: Facilities with a Performance Score two standard deviations below the NW mean (22) as indicated by self-reported data.

Wave 2: Facilities with a Performance Score one standard deviation below the NW mean (22) as indicated by self-reported data.

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 2010 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. Facilities were ranked according to the relationship of their performance scores to the NW mean as either one or two standard deviations below the mean.

Current facility data was collected from facilities that were two standard deviations below the Network mean based on 2010 Elab data. Nine facilities were identified and targeted for intervention.

The first phase of the initiative was rolled out in July 2011. A mandatory WebEx as held in August 2011 to explain the scoring methodology, the facility ranking and the requirements moving forward. A data collection spreadsheet was developed for the initiative and distributed to participating facilities to report monthly data. This spreadsheet automatically calculated scores in both weighted and unweighted categories and allowed facilities and the NW to track scores and improvement on a monthly basis.

Outcome:

After three months of data submission, analysis showed five of nine facilities had demonstrated and sustained scores at or above the NW mean. The remaining four facilities who failed to increase their scores were required to submit improvement plans. Four plans were submitted for review, three plans needed revision before acceptance and one was accepted as written. At year's end, five of the nine continued to submit scores at or above the NW mean. Of the remaining four facilities on a QAPI, two had scores that met or exceeded the NW mean, one showed improvement but still had scores below the mean and one demonstrated no sustained improvement. Data from these two of the original nine facilities included in the initiative will be presented to the MRB for their recommendations.

The second wave of the project will be rolled out in 2012 to ten additional facilities whose scores were one standard deviation below the NW mean. The same plan will be followed and facilities will be required to submit QAPI's if no improvement is demonstrated within three months. Data will still

be collected and monitored from the nine facilities included in the first wave and the NW will await the decision of the board on the two facilities that failed to improve their scores.

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. This is a very challenging indicator to measure and the Network lacks real time data to perform trend analysis. 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

CDC/NHSN Hemodialysis Collaborative:

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. The original plan was that the majority of New Jersey facilities would be enrolled by the end of July 2011, Puerto Rico and the US Virgin Islands would start enrolling after the March 2011 annual education program in Puerto Rico.

The benefits of joining the collaborative included:

- Data would be collected from all NW facilities utilizing the same collection criteria
- Standardized infection reports could be generated for the facilities to share with State Survey Agencies (SSAs) during Federal and State surveys
- The CDC will set up a NW3 group to allow access by NW staff to facility data, facilities will be asked to allow the CDC to share data with the NW
- The Network will have access to facility specific data to allow for targeted intervention based on current data
- Members will have access to best demonstrated practices and assist in establishing standards of care
- Members have the opportunity through in-person meetings and monthly collaborative calls to discuss infection prevention topics and activities which contribute to the design and implementation of interventions
- The CDC provides input on specific challenges from prevention experts
- Receive support for NHSN use and infection measurement from experts at the CDC
- Members have the support from experts in implementation science
- One standard form of reporting for all dialysis facilities

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 and were reporting data. The few remaining facilities are in the process of change in ownership and are awaiting new provider

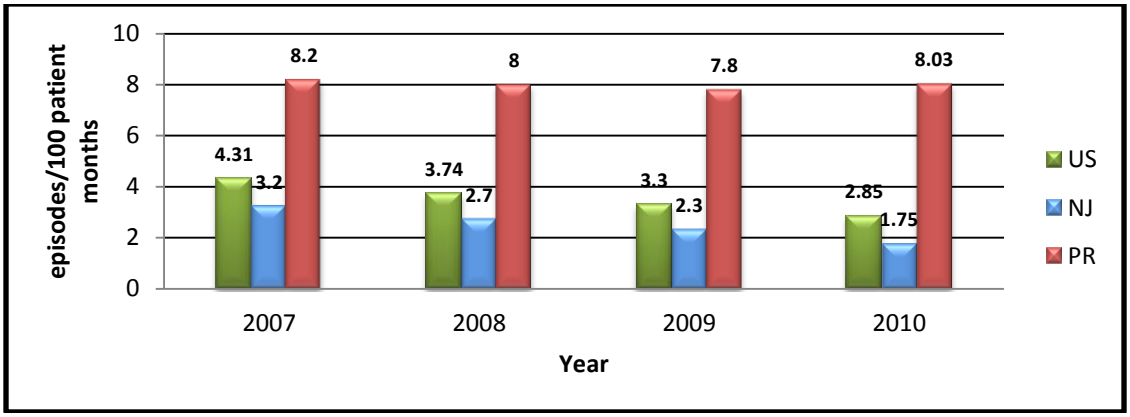
numbers. In 2012 the Network will provide additional training sessions and begin the process of data validation. The Network is collaborating with the New Jersey chapters of Association for Professionals in Infection Control and Epidemiology (APIC) to develop an education program to facilitate communication between the hospital infection control practitioners and the dialysis staff to ensure accurate and complete reporting.

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.

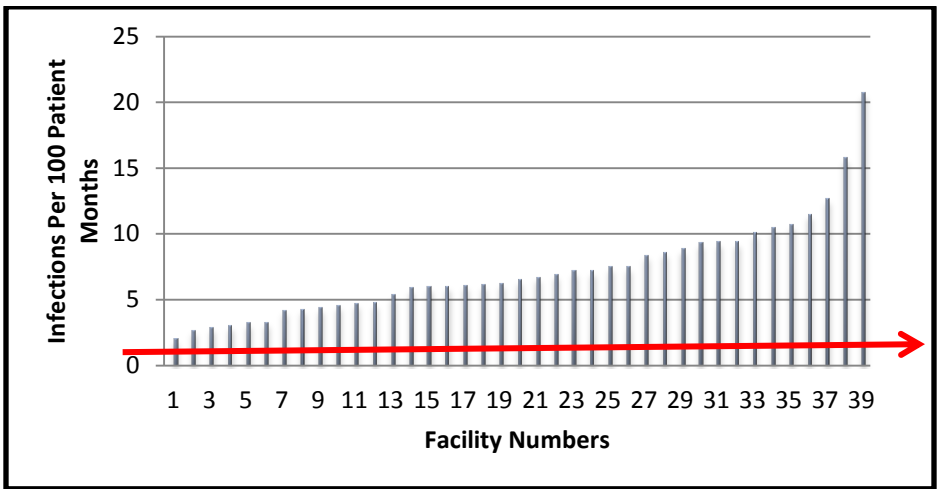
Figure 16: Vascular Access Infection Rate by Region



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* 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 17 below displays the infection rates at the 39 facilities.

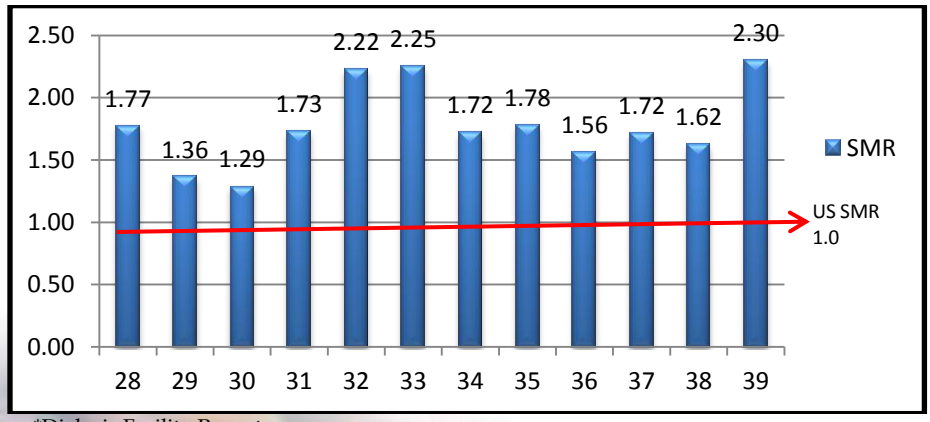
Figure 17: 2010 Infection Rates in Puerto Rico by Facility



*Dialysis Facility Reports

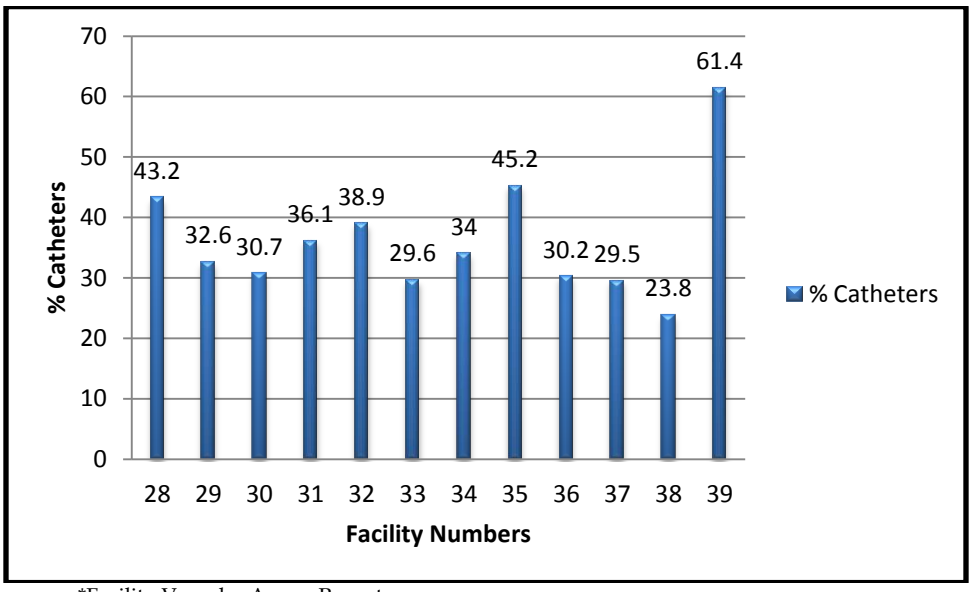
Figure 18 reveals the mortality ratios at the 12 targeted facilities. Facility #39 in Figure 18 had an infection rate of >20/100 patient months according to claims data reported in the Dialysis Facility Report. The mortality ratio at this facility was 2.3 compared to the US mortality ratio of 1.0. Figure 19 shows that facility #39 had a catheter rate of >61%. Only three of the 12 targeted facilities had catheter rates below 30%.

Figure 18: Standarized Mortality Ratio at 12 Targeted Facilities*



*Dialysis Facility Reports

*Figure 19: 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 intervention. 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. 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.

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.

The Network sought the advice of the CDC, who offered possible on the ground assistance, but required an invitation from the Puerto Rico Department of Health. The Network and local Network Board members brought this suggestion to the Secretary of Health in Puerto Rico, who agreed to invite the CDC to conduct surveillance. At the time of this report the invitation has not been extended.

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 will be focused on infection control. 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 agreed to participate.

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 agreed to participate. The meeting is scheduled for March 4, 2012 and registration approaching 300 has exceeded previous years.

On-site visits are scheduled for February 28 through March 3, 2012, during which data validation, staff re-education and technical assistance will be provided.

The last several months of 2011 have 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 care to some extent is performed at home without the provision of supplies or instruction, patients were not washing their vascular access before dialysis, and several process issues, including regular testing of cultures, need to be re-evaluated.

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 will present at the annual meeting on the most frequently cited infection control deficiencies. The DOH was provided with a list of targeted facilities.

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. Improvement is still needed in reporting outcomes during the performance improvement meetings.

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. The regional Medical Director and CEO have become very involved and are supporting efforts at the local level.

One hundred percent of Network 3 facilities are required to report monthly in NHSN in 2012. 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

Outcome data may not be available until July 2012 when the USRDS facility reports are released. The Network hopes to see a downward trend but this may be unrealistic due to the fact that these reports will reflect data from calendar year 2011, and this project was not implemented until late August 2011. QIRN3 has been working with the facilities to ensure accurate data entry into NHSN; therefore, the 4th quarter data from 2011 will not be utilized until validation occurs, which is planned for March 2012.

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 2011, 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 a special breed. 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. Recently 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 12 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 pass control to the newly hired leadership staff. 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 in flux since the beginning of the year. Monthly conference calls with the CMS ESRD Technical Lead for the Northeast Division, the New York Regional Office of CMS and Network staffs continue. 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 but was recently cited for a deficiency during a CMS survey. Monthly calls were restarted 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 3 years.

The hospital-based facility on St. Thomas (Roy Lester Schneider Hospital) was not surveyed during 2011, but continues to conduct 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 2 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 2 years.

The facility is seeking resources to train local technicians and nurses to decrease the utilization of travelers. The financial burden weighs heavily on the success of this dialysis facility.

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 to be 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 developed staff educational modules on different safety topics. Providers register to participate in the program and can select from 13 safety modules, which include the tools and training resources necessary for implementation of each patient safety concept. Facilities may complete as many or as few modules as they wish, with only one component, Patient Safety Principles, being mandatory. As each module is completed, the provider submits a reporting form to the Network, which acknowledges finished activities. Levels of provider recognition have been established as providers move from 1 diamond status to 5 diamonds. This voluntary program is an excellent complementary tool for identifying internal quality improvement opportunities.

By the close of 2011, fifty-five Network 3 facilities had participated in the program. Twenty-four NJ facilities and one from the USVI had achieved 5 Diamond Status. Of the total number of facilities participating, twelve were in Puerto Rico and the US Virgin Islands and the remaining forty-three were in New Jersey. Facilities from all 5 Diamond categories were recognized for their achievement with a certificate in addition to being listed on the Network website and announced at the October 14, 2011 Network Annual Meeting. The program began its second year for NJ participants in September 2011 while facilities from the USVI and Puerto Rico have a few months left to complete their first program year. Plans are to continue and promote the program in the Network areas.

Network 3 participates in quarterly 5 Diamond conference calls with the other participating ESRD networks and recently completed a review and update of the Hand Hygiene Module. The NW also facilitated submission of the Constant Site Cannulation module which was created by a New Jersey facility and accepted for inclusion in the national program.

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: Managing Your Phosphorus; Disaster Preparedness; Fluid Restriction; Skin Cancer Risks; Kidney Transplant; Medicare Coverage for Transplant; Holiday Diet Tips and Immunization. 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
Serving New Jersey, Puerto Rico, and the US Virgin Islands

KIDNEYS R US

FROM THE QIRN3 PATIENT ADVISORY COMMITTEE

September 2011

Five Steps to a Kidney Transplant

1. Educate yourself

If you think a kidney transplant may be good for you discuss it with someone whose opinion you trust: your kidney doctor, dialysis nurse, social worker, family, friends and patients who have had a transplant already. Make your evaluation appointment at the transplant center where you would like to receive a kidney. Remember, it will be the place you will go for your surgery and follow up care immediately after your transplant and until your new kidney is stable enough for you to go back to your regular kidney doctor. Also, while the transplant center staff is evaluating you, you can be evaluating them; after all, they will be taking care of you after your transplant! Ask someone to go with you for company and to help you remember and understand the information you will receive. Two heads are better than one especially since it will be a long and busy day for you. If you think you'd like a transplant but are unsure: go anyway. You will not waste your time and you will know more than you do now about transplant.

2. Take charge

Plan to keep all of your forms and letters from the transplant center, copies of your medical records and any educational materials in a safe place - a folder, large envelope or note-book will do. Look through it regularly. If you have had any of the required blood work or other testing, try to gather copies of it in time for your appointment and bring it with you for the transplant center to copy and return to you. Better yet, have your records mailed or faxed before your appointment date. If you need help, ask the dialysis staff or the staff at your doctor's office for assistance. If you are unable to do this beforehand, you can sign a permission form when you arrive for your appointment so that your medical records can be released to the transplant center.

We Remember... Organ and Tissue Donors

3. Prepare for your evaluation appointment

Be prepared! Bring a list of your medications and doctors you see for special conditions. Be ready to answer questions about your past medical history and to be examined by the transplant team. If you have a condition such as heart disease, hepatitis, HIV, history of cancer or substance abuse, try to have copies of your most recent tests, letters of medical clearance or special blood work with you for the team to look at during the appointment.

4. Keep your evaluation day appointment

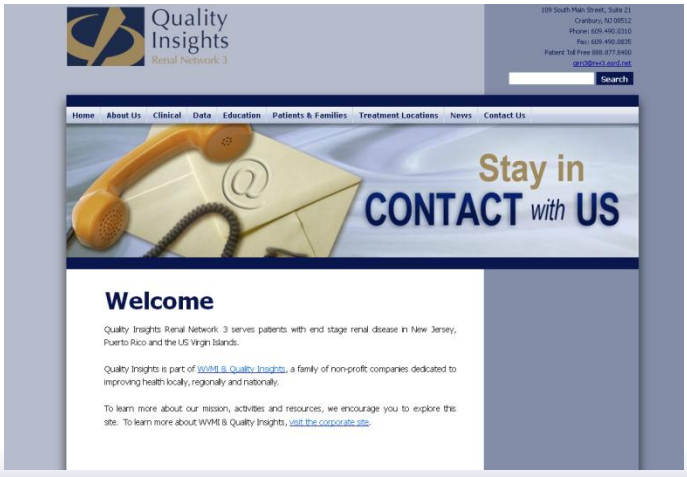
The transplant center will call or send a letter confirming your appointment and provide information about what to bring with you. Bring a snack if you are diabetic. If you have questions or special needs, call the center at least one day before your appointment to discuss. During the session, you will be educated about transplant and meet individually with members of the transplant team. The transplant doctor will examine you and ask about your medical history. Your height and weight will be measured and you will be seen by a dietitian for counseling to help you reach or maintain a healthy weight for the transplant.

The transplant coordinator will interview you as will the social worker and the financial coordinator who will check your insurance coverage for a kidney transplant and anti-rejection medications. The social worker will discuss your thoughts and feelings about transplant and how it will affect you and your family as well as your finances (co-pays and limits of your coverage). If you have a history of alcohol or drug abuse you may need to have additional blood or urine testing, give proof of completing a rehabilitation program or attend one if you have not.

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 64 calls from patients and providers during CY2011 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 apply for the New Jersey Pharmaceutical Assistance to the Aged and Disabled Program (PAAD).

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 CY2011, they are listed below:

- On March 17, 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 and return to employment is one of the benefits of home dialysis.

- On March 31, the Network in collaboration with the National Kidney Foundation and Morristown Memorial Hospital hosted a patient education program in Morristown. The topic was: *CKD: Dialysis Is Not Your Only Option! Learn about all your choices, including kidney & pancreas transplant*.
- On April 7, the 21th 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 27, 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 October 13, the Network held its Annual Meeting. Topics included: AV Fistula, Best Demonstrated Practices; Fluid Management; Enhancing Patient's Self-Management through Inter-disciplinary Team Support and Learning Styles among Hemodialysis Patients and Dietary Phosphorus and Binder Adherence. 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.
- On November 10, the Network and Our Lady of Lourdes Transplant Program co-sponsored a patient education program at the Moorestown Community Center on kidney transplantation and medication management. Transplant surgeons and nephrologists presented and were available to take patient questions.
- 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.

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

Network 3 worked consistently during CY2011 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 2011. 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 third 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 three years; 2009, 2010 and 2011. In each subsequent two month period the number of calls increased as compared to the two months prior to distribution. In 2011, the brochures were sent out in October. The NW received sixteen complaint calls in November and December. In the two prior months, August and September, there were four complaint calls received. This strategy has proven, over these three years, to be successful in increasing patient and family awareness of the availability of NW3 to investigate complaints involving dialysis and transplant facilities.

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 four formal grievances in CY2011. The Network investigated seventy-four complaints in CY2011; thirty-two were for treatment related/quality of care issues. Staff related and physical environment were the next most commonly cited reasons for complaints with twenty and nine 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. NW3 tracked a significant increase in the number of Involuntary Discharge Contacts in 2011as compared to 2010. Part of the reason for this increase was due to the NW tracking of patients affected by IVD when their facility closed due to flooding from Hurricane Irene. 149 patients were involved in a contact to NW3 involving IVD in 2011. Of those, fourteen involved IVD not related to a facility closure. Ten of these contacts involved verbal threats of physical violence or physical abuse from a patient towards a staff member. One case was for lack of payment. Two were the result of a nephrologist discharge and one was because the facility could no longer meet patient's medical needs. Six of the cases resulted in the patient being transferred to another outpatient dialysis facility. Seven patients remained in their facility after NW intervention. One patient was an unauthorized immigrant to Puerto Rico and returned to her native country.

Sixteen of the IVD patients were from Governor Juan Luis Hospital. These patients were transferred to the Caribbean Kidney Center due to a CMS mandate.

Thirty-two patients were transferred out of two facilities when there were facility closures in Manahawkin, NJ and Parsippany, NJ. These patients were all transferred directly to other providers without interruption of care.

Eighty-seven patients were involuntarily discharged to another outpatient provider due to the temporary closure of two dialysis providers due to flooding from Hurricane Irene. These providers were located in Newark, NJ and Somerville, NJ. This occurred in August and resulted in the temporary relocation of patients. These eighty-seven patients were to be transferred back to these two providers after the facilities were rebuilt.

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 2011, 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 Managing Your Phosphorus; Disaster Preparedness; Fluid Restriction; Skin Cancer Risks; Kidney Transplant; Medicare Coverage for Transplant; Holiday Diet Tips and Immunization. Information about NW3, the patients' toll-free number, the web site address and information on joining the PAC were included in every newsletter.

The 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 March 31, 2011at Morristown Memorial Hospital in Morristown, NJ and November 10, 2011 in collaboration with Our Lady of Lourdes Medical Center in Moorestown, NJ.

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 2011, ninety-eight patients had signed up to be Patient Representatives from 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 a 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 ESRD Technical Lead 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 developed for 2012. A total of 6 programs will be held and topics include: hemodialysis hands-on training, NHSN registration which will be a collaborative effort between NWs 1 and 3; prioritizing surveys, handling complaints, 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 the other to address the specific needs of Puerto Rico and the US Virgin Islands.

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

- January 25, 2011 with 33 attendees,
- May 5, 2011 with 56 attendees,
- July 7, 2011 with 61 attendees,
- October 4, 2011 with 98 attendees

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

- July 14, 2011 with 35 attendees
- October 11, 2011 with 27 attendees

Representatives attended from St. Thomas and St. Croix.

The Network provided the Council members with the quarterly conference call schedule from July 2011 through to April 2012 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:

- Local issues/concerns
- webinars
- Educational needs
- Unintended consequences of bundling
- Suggestions for annual meeting, including RDs and SWs breakout sessions
- Educational Patient and Professional Education programs
- Preparation for the hurricane season
- CDC Hemodialysis Collaborative
- 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.

During 2011 the Coalition achieved the following:

- Revised the Medical Director Report to focus 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 Medical Director Card was distributed quarterly.
- The patient education program, "*CKD: Dialysis Is Not Your Only Option! Learn about all your choices, including kidney & pancreas transplant*" was held on March 31, 2011 at Morristown Memorial Hospital. The program was co-sponsored with the National Kidney Foundation.
- The Coalition provided a professional program on October 3rd, 2011 at Overlook Hospital on CKD, "*Chronic Kidney Disease – Transitioning to End Stage Disease*". The program included the following presentations: An Overview of CKD Diagnosis and ESRD, Vascular Access, Social Worker Working with ESRD Patients & Dialysis Center Placement, Dietary Implication: Moving from Early Kidney Disease, Complications of an End Stage CKD Patient and End of Life & the Renal Patient. The coalition obtained 2.5 educational contact hours for the MDs, nurses and dialysis technicians.
- The program, "*Chronic Kidney Disease, A Mini Symposium*" was held on November 3, 2011 for physicians and nurses at East Orange General Hospital. The topics included early recognition of CKD, risk factors in CKD, co-morbidities, cardiovascular disease and a team approach to manage the progression of CKD. The coalition obtained 3.0 educational contact hours for the MDs, nurses and dialysis technicians.
- The Coalition collaborated with Our Lady of Lourdes to provide a workshop for patients to learn about the transplantation process on November 10, 2011. The topics included: CKD, Transplantation and the Living Kidney Donor Transplantation, Kidney and Pancreas Transplantation and Medications.

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 data used for this report was collected from the vascular access data collection tool and the CMS- 2728 form.

In 2011 the NJRC collaborated with the Patient Advisory Committee (PAC), the National Kidney Foundation, Morristown Memorial Hospital, Overlook Hospital, East Orange Hospital, Our Lady of Lourdes 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:

- March 31, 2011, the NJRC co-sponsored a patient education program with the National Kidney Foundation and the Morristown Memorial Hospital in Morristown, New Jersey. The topic was: CKD: Dialysis Is Not Your Only Option! Learn about all your choices, including kidney & pancreas transplant.
- October 3, 2011, the Coalition provided a professional program at Overlook Hospital on CKD, "Chronic Kidney Disease – Transitioning to End Stage Disease". The program included the following presentations: An Overview of CKD Diagnosis and ESRD; Vascular Access; Social Worker Working with ESRD Patients & Dialysis Center Placement; Dietary Implication: Moving from Early Kidney Disease; Complications of an End Stage CKD Patient and; End of Life & the Renal Patient.
- November 3, 2011, a primary care physician program, "Chronic Kidney Disease, A Mini Symposium" was held at East Orange General Hospital in East Orange, New Jersey. The topics included: Early Recognition of CKD; Risk Factors in CKD; Co-Morbidities; Cardiovascular Disease and; A Team Approach to Manage the Progression of CKD.
- November 10, 2011, the Coalition collaborated with Our Lady of Lourdes in Moorestown, New Jersey to provide a work shop for patients to learn about the transplantation process. The topics included: CKD; Transplantation and the Living Kidney Donor Transplantation; Kidney and Pancreas Transplantation and; Medications.

Emergency/Disaster Preparedness and Response

In 2011, 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 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 August 2011, Hurricane Irene had a major impact on NW3. The storm passed through the islands and impacted Puerto Rico and the Virgin Islands with heavy rains that resulted in downed trees and localized flooding. There was no impact on the operations of the dialysis facilities on the islands.

Hurricane Irene had a major impact in NJ on August 28, 2011when it hit land and the immediate days after as the flooding caused extensive damage throughout the state. Prior to landfall, the Network was in communication with all facilities in NJ to discuss emergency planning. Daily weather alerts from the NJ OEM were distributed via email to all providers. Information on facility preparedness and patient preparedness were provided to the facilities. Landfall occurred on a Sunday which was a relief to both patients and staff, since this is the one day of the week when no patients are dialyzed in dialysis units. The storm had a major impact on the state in regards to flooding. The winds caused localized damage; however, flooding had an impact throughout the state.

The NW communicated with facilities in the days following the hurricane to determine the status of operations. This information was communicated to CMS and KCER during follow-up conference calls arranged by KCER. Two facilities were flooded in NJ; one in Newark and one in Somerville. Both required the transfer of all patients to other facilities until such time the facilities could be re-built. One facility in Trenton is located in Water's Edge Nursing Home that was evacuated during the hurricane due to concerns about flooding from the Delaware River. The patients who are treated at this facility and reside in the nursing home were transferred to local hospitals until they could return to the nursing home. These patients received dialysis while housed at the hospital. The

information on all facility closures was added to the website: www.dialysisunits.com by the Network to ensure the facility status was available to patients and providers to locate as needed. Information was update on the website as circumstances changed. The Network handled two calls from patients who were unsure about the status of operations at their facilities. These patients were informed of the status of the facilities and were provided with contact numbers to call to confirm their dialysis schedules.

Tropical storm Lee caused additional flooding to NJ when it arrived in early September 2011 as the state was continuing to clean up from Hurricane Irene. The rainfall from Tropical Storm Lee was calculated to be close to 10 inches in some areas of the state. Rivers overflowed and resulted in flooding again around several dialysis facilities in the state. There were no long term closures as the result of this storm. Facilities adjusted their schedules to accommodate patients who had difficulty getting to dialysis for their scheduled treatment time.

On October 31, NJ was hit by an early snow storm. The snow accumulating on trees still laden with leaves resulted in many power lines down. Several dialysis facilities required the use of their back-up generators until power was restored. There was no disruption to patient care during this storm.

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 7, 2011 and with the Penn Transplant Institute – Kidney Transplant Program Annual Nursing Symposium for Dialysis and Nephrology Nurses, University of Pennsylvania on April 26, 2011.

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 is working 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 to develop a Learning and Action Network to provide consumer and professional education on decreasing healthcare associated infections. The first face-to-face meeting is scheduled for March 2012.

Annual Network Education Programs

On October 13, 2011, the Network held the Quality Insights Renal Network 3 (QIRN3) Annual Education Program. . Approximately 440 dietitians, social workers, physicians, nurses and patients attended the meeting. Guest speakers included:

- Robert Provenzano, MD, FACP "*ACO's-What Does it Mean to Nephrologists*?"
- Steven Fishbane, MD, "*Maintaining Desired Outcomes in a Bundled Environment*"
- Richard Goldman, MD, "*How to Cope With Disruptive Behavior in the Dialysis Facility*",

- Panel Discussion: St. Joseph's Medical Center and Morristown Medical Center *AV Fistula - Best Demonstrated Practices*
- Kay Deck "*Fluid Management.*"

Afternoon breakout sessions for social workers and dietitians included:

Social Workers

- Joseph Merighi, MA, MSW, PhD and Lisa Eliza Vanderstar, MSW, LCSW, JD, "*Enhancing the Dialysis Patient Self-Management Through Inter-Disciplinary Team Support*"
- James Flack, MD, "*Working With the Psychotic Dialysis Patient*".

Dietitians

- Melissa Altman-Traub MS, RD, CSR, LDN, "*Inflammation in CKD Stage 5*"
- Deena Natale, MS, RD, "*Learning Styles Among Hemodialysis Patients and Dietary Phosphorus and Binder Adherence.*"

The program 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.

Registrants were asked to complete an evaluation of the event and to evaluate the effectiveness of Network activities over the last 12 months. The Network received an 8.7 effectiveness score on a scale of 1-10. There was an 11% overall improvement in scores from 2010. The participants were asked to select areas in which the Network could improve; staff education and patient education received 38% and 23% of the responses respectively.

The dialysis facility staff were invited to feature specific internal quality projects for the benefit of all meeting participants. Twenty posters were displayed at the 2011 annual meeting:

Booker Outpatient Dialysis at Riverview MC
Medication Reconciliation: Coumadin
Vimla Christian, RN, CNN

Fresenius Medical Care
Becoming Dialysis Ready - Pre-ESRD Treatment Options Education
Jessica Phipps, MSW, LSW

Fresenius Bloomfield
The Influence of Cost and Phosphorus Binder Type on Adherence in the Hemodialysis Population
Claire Fleming, MS, RD

Fresenius Hoboken and Harrison
The Emotional Effects of ESRD
Anita C. Kahan, MSW, LSW

Fresenius Kenilworth
Dialysis Patient-Family Education and Support Group- A Vehicle to Wellbeing
Baktha Kumar, MSW, LCSW, Jessica Phipps, MSW, LSW, Karola Behringer, RN

Fresenius Kenvil
A Team Approach to Care
Donna Buglisi, BSN, RN, CNN, Shan-Li Chen, RD, MBA, Barbara Tepper, LLSW, ACSW

Fresenius Kings Court Flemington
***QOL**: Reaching Your Personal Best*
Julie Somers, LCSW, MSW, Med, Emily Delgado, RN

Jane H Booker-JSUMC
The Nutritional Importance of the Breakfast Meal
Beverly Crudup, CCNT, Mauren Heilmann, RD, CDE, Jane Reinertsen, RD, CDE

Liberty Berlin
KDQOL
Eleanor Witkowski, MSW, LSW

Liberty Hammonton
Rehabilitation
Eleanor Witkowski, MSW, LSW

Liberty Linwood
Emergency Preparedness: Are You READY for Any Emergency
Jennifer Geiger, MSW, LSW

Liberty Runnemede
"Domestic Violence and Its Effects on Dialysis Patients"
Jennifer Geiger, MSW, LSW

Morristown Medical Center & Dialysis Center of Northwest Jersey
"Best Practices for AVF"
Mary Buckley-O'Dell, MBA, RN, CNN, NE-BC, Paul Fine, MD, Kathleen Vnenchak BSN, RN, CNN
Madeline McLoughlin BSN, RN, CNN, Phoebe Aliparo BSN, RN, CNN

Our Lady of Lourdes Medical Center
"Cannulation Techniques"
Marcia Kopytko, RN

RCG Renal Institute Toms River
"Access Placement"
Sally Barberi, RD, Noemi Tomlin, PCT Maureen Reilly, Joyce Rod-Segal, MSW
Eleanor Maghintay, RN, Joyce Rod-Segal, MSW, Nichole Phelman, PCT
Raquel Gernale, RN, Joann Clarke, PCT, Haydee Martinez,

RCG Renal Institute Toms River
"Access Maintenance"
Hope S. Wiles, MSW, Maritess Reyes, RN, Brenda Broomer, Sheri Dubinsky, RD
Charmaine Dionisio, RN, Violina Martinez, RN, Lynn Lopiccolo, Ann Panten, RD
Donna Solminski, RN, Marilou Leano, Lolita Mauleon

RCG Renal Institute Toms River
"Access Development"
Deborah Ogorzalek, RN, Haven Panganiban, Wilma Arellano, RN, Michael Ornstein,
Lisa Tatesure, Sol Geronimo, RN, Mario Salazar

RCG Renal InstituteToms River
"Access is Your Lifeline"
Barbara Robinson, RN, Maritess Leano, Bonnie Stepowany, Mayo Severino
Vivian Belda, RN, Lenny Bautista, Jennifer Tatesure, Ellen San Rafaele, RN
Erna Loterna, RN, Elaine Kess, James Pinda

Shore Dialysis Center
"The Effect of Protein Education on Serum Albumin Levels"
Andrea Cortellessa, RD, CSR, Peggy McFarlane, MS, RD, Marge Fellenbaum, MSN, RN

Shore Dialysis Center
"The Effect of Interactive Activity on Serum Albumin Levels"
Andrea Cortellessa, RD, CSR, Peggy McFarlane, MS, RD, Marge Fellenbaum, MSN, RN
Fran Hatcher, ASN, RN, Sandee Hartman, MSN, APN

Annual Puerto Rico Education Program

On March 8, 2011, the Network held the Quality Insights Renal Network 3 (QIRN3) Annual Puerto Rico Education Program. Approximately 100 administrators, nurses and physicians attended the meeting. Guest speakers included Christopher W. Brown, BS who discussed the "*Clinical Outcomes and the Network Initiatives*", Joan Wickizer, MSW, LSW, who presented "*Hospice and ESRD: Understanding the Medicare Regulations*", Beverly Hoek, RN, CNN, the "*CDC Hemodialysis Collaborative*" and Karen Ripkey, BSN, RN, CNN with the "*5 Diamond Patient Safety Program.*"

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.

2011 Educational programs

During 2011, the NW provided twenty-seven educational programs, an increase of 56% from 2010, 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 8 CPEUs, nurses and technicians28.5 CEUs, physicians 10.75 CMEs and social workers 6 CEUs. The Network continued to provide at least quarterly provider and monthly patient education in 2011.

Program Title	Date	Number of Attendees	Number of Dialysis Units Represented
Patient Education Lobby Day	March 2	60	1
Annual Education Program Puerto Rico	March 8	102	38
Home Designee	March 17	104	71
Infection Reduction Initiative	March 22	74	45
Transplant Designee	April 7, 26	431	186 (NJ, NY, PA)
Effect of Tobacco Use and Secondhand Smoke on Diabetes	April 21	44	26
Improving Buttonhole Cannulation	May 3	150	90
QAPI Spreadsheet	May 9	4	1
Network CMS Forms Review	May 19	12	6
Network Annual Goals	May 20	124	91
Understanding your Facility Performance Scores	August 23	19	10
Patient Education Lobby Day	September 8	60	1
Puerto Rico Strategic Planning Infection Reduction	September 15	24	13
FMC and DaVita Facility Administrators Meetings	September 22,23	59	7
CKD-Transitioning to ESRD	October 3	74	12
National Healthcare Safety Network Registration Webinars	October 11,17	97	64
Annual Education Program New Jersey	October 13	444	127
Infection Control Best Demonstrated Practice	November 2	77	29
New Trends for Early Treatment of CKD	November 3	66	12
National Healthcare Safety Network Registration Webinars	November 10, 30	105	85
Importance of PTH and Risks Associated with Abnormal PTH Levels	November 17	131	68
National Healthcare Safety Network Registration Webinars	December 1, 2, 7	87	82
NJ DOH Universal Transfer Form.	December 20	64	56
Patient Education Lobby Day	December 28	32	1

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.

SIMS

SIMS is an integrated system that provides communication and data-exchange links among the Networks, facilities, and CMS. Each Network has a local database where patient, facility, and facility personnel data are entered and maintained. Through an automated data transfer application, the SIMS database was replicated to the central repository on a nightly basis.

SIMS has the capability to produce various reports used by Networks to ensure facility reporting accuracy. In particular, the annual CMS-2744 form was completed, and used to validate patient activity throughout the year. The validated data is patient-specific and provides elements such as age, race, sex, ethnicity, diagnosis and modality/setting of care, as well as patients' county and state of residence. This information was used to reconcile the SIMS database.

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 sent these records to the appropriate facility once each month, where the facility verified the data, and returned to the Network office the correct information.

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 total number of forms transmitted, 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.

CMS Notifications

CMS notifications are requests for patient database validity information. Each month notifications were sent to those facilities where discrepancies were noted by CMS. Facilities then reviewed the element in question and either reported the value as correct or provided to QIRN3 with the corrected data element. The corrected/validated information was entered in the SIMS database, which ensured accurate data in the national database and REMIS.

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

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.

CMS sets a goal for Networks that require them to ensure that facilities submit 90% of forms accurately and on time. Due to increased education and support for facilities who struggle meeting these requirements, in 2011 Network 3 exceeded the goal for both timeliness and accuracy.

QIRN3 staff entered data from the forms into computer software supported by the federal government. 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.

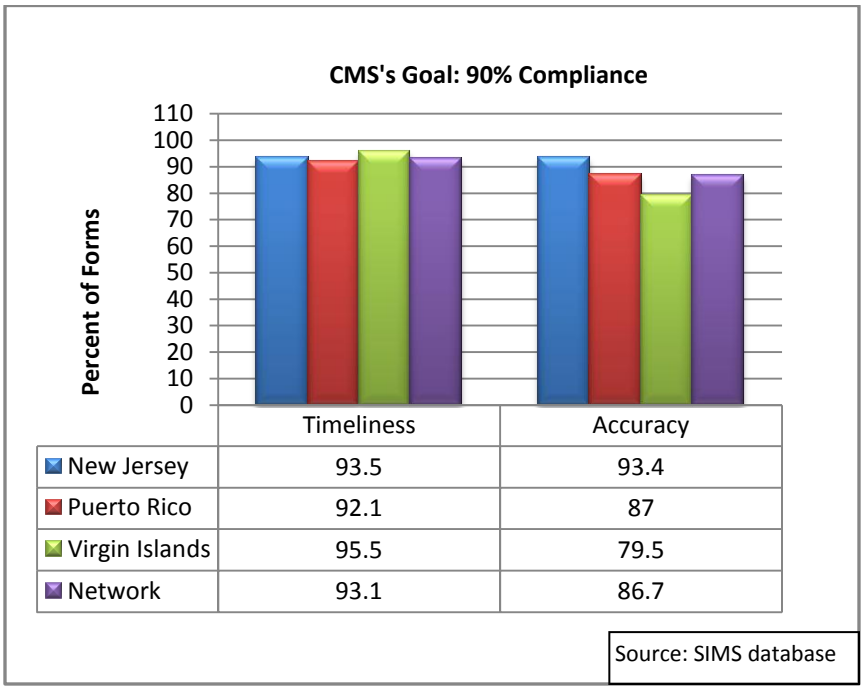
QIRN3's dialysis facilities submitted 5,329 Medical Evidence Reports (CMS-2728) during the year. Out the forms submitted 4,963 (93.1%) were on time and 4,872 (91.4%) were accurate.

New Jersey facilities submitted 3,764 forms, of which 3,520 (93.5%) were submitted on time, and 3,514 (93.4%) were completed accurately.

Facilities in Puerto Rico submitted 1,521 forms of which 1,401 (92.1%) were on time and 1,323 (87.0%) were completed accurately.

Forty-four forms were received from the Virgin Islands of which 42 (95.5%) were on time and 35 (79.5%) were accurate.

Figure 20. Percent of CMS-2728 Forms Received by Timeliness and Accuracy



ESRD Death Notification form (CMS-2746)

The ESRD Death Notification form is due within 30 days of a patient's death. QIRN3's 2746 forms compliance exceeded 90% in both timeliness and accuracy.

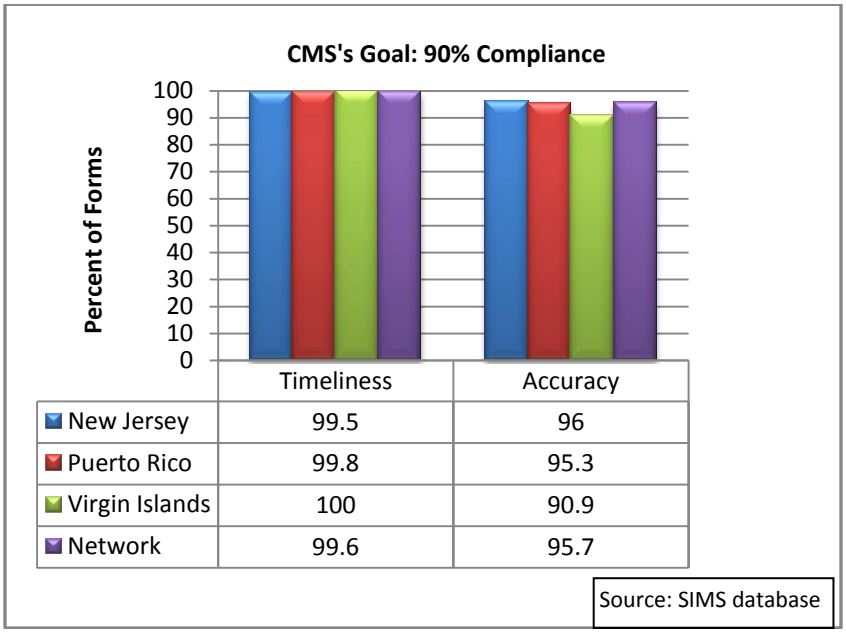
Facilities in Network 3 submitted 3,781 death notification forms during the year, of which 3,765 (99.6%) were on time and 3,620 (95.7%) were accurate.

New Jersey dialysis units submitted 2,579 death notification forms during the year, of which 2,565 (99.5%) were on time and 2,476 (96.0%) were accurate. New Jersey exceeded both accuracy and timeliness goals.

Puerto Rico's dialysis programs submitted 1,180 death notification forms of which 1,178 (99.8%) were on time, and 1,124 forms (95.3%) were completed accurately. Puerto Rico also exceeded the goal for accuracy and timeliness.

The 3 Virgin Island facilities submitted 22 death notification forms of which all were received on time and 20 (90.9%) of which were completed accurately. Virgin Islands facilities also exceeded the goal for accuracy and timeliness.

Figure 21. Percent of CMS-2746 Forms Received by Timeliness and Accuracy



	Timeliness	Accuracy
New Jersey	99.5	96
Puerto Rico	99.8	95.3
Virgin Islands	100	90.9
Network	99.6	95.7

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. 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 quarterly and documented. Both federal forms were profiled for compliance rate analysis.

UNOS

Renal transplant registrations and follow-ups were resolved through updates and verifications within the SIMS and UNOS databases. Data were received monthly from UNOS and entered into the SIMS database. Discrepancies were reviewed with transplant facilities and accurate reconciliation of patients was obtained through the SIMS report summary.

VISION

CMS requires that patient and physician signatures on 3% of all CMS-2728 (Medical Evidence Reports) forms submitted through VISION be verified annually. IN 2011, QIRN3 received 1,246 CMS-2728 forms through VISION and thus were required to verify 37 forms; 37 forms were randomly requested and received from 31 facilities. All but one of the 37 forms had patient and physician signatures on them. One form was missing the patient signature due to the patient expiring.

REMIS

The federal REMIS system is an important component of the CROWN system and is based on federal billing records. Data entered into SIMS 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.

CROWNWEB

CROWNWeb is a web based application that is part of the CROWN application suite which includes: SIMS, REMIS, and VISION. It supports the collection of patient records, clinical performance measures, and facility data and will ultimately replace SIMS and VISION. In 2011, the data management staff at Network 3 took part in many CROWNWeb Phase IIe (extended) activities including: data entry and data discrepancy resolution, facility support, facility recruitment and more.

In early 2011, Network 3 worked to register QualityNet Identity Provisioning System (QIPS) security administrators for nearly every facility in the Network. QIPS is the main user administration interface that is used by CROWNWeb to create new user and security administration accounts. At the midpoint of 2011, 100% of Network 3 facilities were registered with QIPS Security Administrator Accounts.

In 3Q 2011, ESRD Networks were told that despite promises to the contrary, users with QIPS accounts would not be transitioned to the new identity system, the QualityNet Identity Management System (QIMS). When QIMS is released in January 2012, all users will be required to re-register for the system.

Network 3 also recruited facilities for the next planned phase in CROWNWeb, Phase III, which increased the number of facilities participating from 10 (5 large dialysis organizations and 5 independent organizations) to 20 (10 dialysis organizations and 10 independent). This phase of

CROWNWeb was not deployed in 2011, but Network 3 met CMS expectations by enlisting the facilities required.

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

QIRN3 continued to support VISION software by training facility staff in existing facilities when assigned staff changed. No new VISION facilities were trained in 2011.

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 2011.

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.